DEPARTMENT OF MANAGED HEALTH CARE
FINAL TEXT OF PROPOSED REGULATIONS

Changes in Text to "Director" and "Department of Managed Health Care"

TITLE 28. MANAGED HEALTH CARE

DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE

CHAPTER 1. DEPARTMENT ADMINISTRATION

ARTICLE 1. CONFLICT OF INTEREST

28 CCR 1000 (2002)

§ 1000. Conflict of Interest Code for the Department of Managed Health Care

The Political Reform Act, Government Code Section 81000, et. seq., requires state and local government agencies to adopt and promulgate conflict of interest codes. The Fair Political Practices Commission has adopted a regulation (Title 10, California Code of Regulations (CCR), section 18730) which contains the terms of a standard conflict of interest code, which can be incorporated by reference in an agency's code. After public notice and hearing it may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 10 CCR, section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation, and the attached Appendix designating officials and employees and establishing disclosure categories, shall constitute the conflict of interest code of the Department of Managed Health Care.

Designated employees shall file statements of economic interests with the Office of Administration of the Department of Managed Health Care, which will make the statements available for public inspection and reproduction. (Government Code, Section 81008). Upon receipt of the statement of the Director of the Department of Managed Health Care, the Office of Administration shall make and retain a copy and forward the original to the Fair Political Practices Commission. Statements for all other designated employees will be retained by the Office of Administration of the Department of Managed Health Care.

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code; Section 87300, Government Code. Reference: Sections 87300-87302 and 87306, Government Code (the Political Reform Act).

HISTORY:

1. New chapter 1, article 1 (section 1000), section and appendix filed 12-12-2001, including editorial renumbering of former chapter 1 to chapter 2; operative 1-11-2002. Approved by Fair Political Practices Commission 10-3-2001 (Register 2001, No. 50).

Appendix

Designated Positions	Assigned Disclosure Categories
Director, Department of Managed Health Care	A, B
Chief Deputy Director	A, B
Legal Advisor, Office of the Director	A, B
Deputy Director, Communications and Planning	A, B
Deputy Director, External Affairs	A, B
Medical Advisor to Directors Office	A, B
Assistant Director, Plan & Provider Relations	A, B
Assistant Director, Financial Solvency Standards Board	A, B
Chief Assistant to the Director	A, B
Supervisor, Office of Educational Resources Development	A, B
Supervisor, Community Outreach	A, B
All Counsel, supervisory or nonsupervisory, regardless of level, wherever assigned	A, B
All Health Analysts, supervisory or nonsupervisory, regardless of level, wherever assigned	A, B
All Health Program Specialists, supervisory or nonsupervisory, regardless of level, wherever assigned	A, B
All Examiners, supervisory or nonsupervisory, regardless of level, wherever assigned	A, B
Supervisor, Office of Complaint Response and Regulation Division Assistant Deputy Director, Office of Health Plan Oversight	A, B
Assistant Deputy Director, Office of Oversight Standards and Research	A, B
Assistant Deputy Director, Office of Legal Services	A, B
Assistant Deputy Director, HMO Help Center	A, B
Assistant Deputy Director, Office of Technology and Innovation	A, B
Assistant Deputy Director, Office of Enforcement	A, B
Assistant Deputy Director, Office of Administration	A, B
Chief, Division of Financial Oversight	A, B
Chief, Division of Surveys	A, B
Nurses, wherever assigned	B
Consultants used by the Office of Technology and Innovation	B, C
Supervisor, Accounting Section	B, C
Supervisor, Business Management Section	B, C
Supervisor, Application Support Section	B, C
Supervisor, Support Services Section	B, C
Application Architect	B, C
Lead Systems Engineer	B, C
Other Consultants*	A*

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*Consultants shall disclose pursuant to the broadest disclosure category in the code (Category A) subject to the following limitations:
The Director of the Department of Managed Health Care may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Director's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code. Nothing herein excuses any such consultant from any other provisions of this Conflict of Interest Code
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Disclosure Categories

Category A

Each "designated employee" in this category shall report:

(1) Income from any source, investments in any business entity, or business positions in any entity which has "transacted business" with the Department or has been the "subject of any legislation or rulemaking activity" during the previous two years or which the employee has reason to know is planning to transact business with the Department or be subject of any legislation or rulemaking activity.

(2) Any real property which during the preceding two years was rented, leased, or sold to a business entity, or leased or purchased from a business entity, which has transacted business with the Department or been the subject of any legislation or rulemaking activity during the preceding two years or which the designated employee knows or has reason to know is planning to transact business with the Department or be the subject of any legislation or rulemaking activity.

(3) For purposes of this category, "transacting business with the Department" includes, but is not limited to, any activity or contact with the Department in connection with a permit, order, registration, license, certificate, opinion, complaint known to or directly involving the employee, or enforcement action known to or directly involving the employee. A business entity has been or will be "the subject of any legislation or rulemaking activity" if the business entity is, was, will be, or would have been directly affected by any legislation or rule in connection with the laws over which the Department Director has jurisdiction, whether or not such legislation or rule was enacted, adopted, amended, or repealed.

Category B

Each "designated employee" in this category shall report:

(1)(a) Income from any, source, investments in any business entity, or business positions in any business entity which is subject to, or which the designated employee knows or has reason to know may be subject to, or by rule of the Director exempted from, the provisions of the Knox-Keene Health Care Service Plan Act of 1975.

(b) Income from any source, investments in any business entity, or business positions in any business entity which provides medical services, including but not limited to, privately owned hospitals, medical clinics, laboratories, pharmacies, and ambulance companies.

(c) Income from any source, investments in any business entity, or business positions in any business entity which provides training or education for persons engaged in medical service activities or programs.

(2) Real property which during the preceding two years was rented, leased or sold to a business entity, or leased, or purchased from a business entity, which is subject to, or which he or she knows or has reason to know may be subject to, or by rule of the Director exempted from the provisions of the Knox-Keene Health Care Service Plan Act of 1975.

Category C

Each "designated employee" in this category shall report:

(1) Income from any source, investments in any business entity, or business positions in any business entity which is, of the type that, during the preceding two years provided the Department of Managed Health Care or its immediate predecessor agency (the Department of Corporations) with services, supplies, materials, machines, equipment or office space.

(2) Real property which during the preceding two years has been rented, leased or sold to a business entity or leased or purchased from a business entity, which is of the type which during the preceding two years has provided, the Department of Managed Health Care or its predecessor agencies (i.e., the Department of Corporations) with services, supplies, materials, machines, or office space.

28 CCR 1300.43.3 (2002)
§ 1300.43.3. Rural Ambulance Plans

(a) A health care service plan which provides pursuant to a plan contract only ambulance services to subscribers and enrollees located in one or more rural service area is exempted from all provisions of the Act except those provisions hereinafter specified, subject to the condition that such plan give written notice to the Director of its intention to rely upon this exemption, signed by an officer or partner of the plan or its sole proprietor, as the case may be, such notice to be in the following form and contain the following information:

DEPARTMENT OF MANAGED HEALTH CARE
State of California

NOTICE OF INTENTION TO RELY UPON THE RURAL AMBULANCE PLAN EXEMPTION UNDER THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

Date .....

The Plan named below hereby files notice with the Director of the Department of Managed Health Care of its intention to rely upon the rural ambulance plan exemption set forth in Section 1300.43.3, Title 28, California Code of Regulations, and makes the following statements in connection therewith:

1. Name of Plan

Mailing address of Plan

Number and Street or P.O. Box City State Zip

Fictitious name used in business (if none, so state)
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2. Form of organization of Plan

(State whether the Plan is a corporation, partnership, sole proprietorship or other form of organization and, if "other," explain in an attachment.)
The name of each person owning 10% or more of the ownership interests in the Plan is:
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--- ---
--- ---

3. The Plan serves only the rural service area or areas (as defined in Subsection (c) of Section 1300.43.3, Title 28, California Code of Regulations) which is (are) identified on the attached map. No such area contains any part of any city or town which has a population of 25,000 or more persons.
(Attach a map which clearly delineates the area(s) served by the Plan.)

4. The number of subscribers, enrollees and family units served by the Plan is as follows:

Number of subscribers ---
Number of enrollees ---
Number of family units ---
(See Subsections (c) and (o) of Section 1345 of the Knox-Keene Health Care Service Plan Act of 1975 for the definitions of "subscriber" and "enrollee.")

5. The books and records of the Plan are maintained at the following location:

Number and Street City State Zip
The name of the person having custody of such books and records is:

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6. Attached is a brief description of the Plan, setting forth the following items of information:

a. The street address of each of the Plan's business locations, and a description of the functions of each such facility.

b. The number of ambulances owned or operated by the Plan and their customary locations.

c. A brief description of the Plan's history, including the date it initially contracted with subscribers pursuant to a plan contract, whether it offers different types of plan contracts, and the source of its subscriptions (i.e., group contracts, individual subscriptions, advertising, other solicitation).

d. Any significant changes in the Plan which are anticipated during the next 12 months.

7. The Plan hereby gives the following undertakings to the Director of the Department of Managed Health Care:

a. That it has a currently effective license pursuant to Articles 1 and 2 of Chapter 2.5 of Division 2 of the California Vehicle Code, and that it will maintain such license in good standing while operating pursuant to the rural ambulance plan exemption.

b. That the Plan will not receive prepaid or periodic charges pursuant to its plan contract for more than one year in advance.

c. That it will file an amendment to this notice within 30 days of any material change in the information provided pursuant to items 1, 2, 3, or 5.

d. That it will give written notice to the Director of the Department of Managed Health Care within 15 days in the event it terminates its operations as a health care service plan.

e. That it will comply with Sections 1360, 1365(a), 1373, 1379, 1381, and 1385, and with Subsections (a), (d) and (f) of Section 1384 of the Knox-Keene Health Care Service Plan Act of 1975.

f. That it will deliver to each subscriber a copy of its plan contract, and that such contract will prominently display the following legend: "(Name of Plan) is a health care service plan operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975. Complaints regarding this contract and the services furnished thereunder may be directed to the Director of the Department of Managed Health Care of the State of California."

g. That, if any disclosure form or evidence of coverage is used by the Plan, each such disclosure form and/or evidence of coverage will comply with Sections 1362 and 1363 of the Knox-Keene Health Care Service Plan Act of 1975 and the rules of the Director of the Department of Managed Health Care pursuant thereto.

8. The Plan has caused this Notice to be signed on its behalf by the undersigned, thereunto duly authorized.

Name of Plan---

By---

Title---

The following verification is to be executed by the person signing the Notice on behalf of the Plan:

I certify under penalty of perjury that I have read this Notice and the attachments thereto and know the contents thereof, and that the statements therein are true and correct.

Executed at ..... on .....

(City and State) (Date)

Signature of Declarant

(If executed in a jurisdiction which does not permit verifications under penalty of perjury, attach a verification executed and sworn to before a notary public.)

(b) A plan's exemption pursuant to this rule may be terminated by order of the Director, upon a determination that such action is in the public interest and for the protection of subscribers and enrollees, for any of the following reasons:

(1) The plan is operating at variance with the documents and information contained in its current notice filed pursuant to Subsection (a).

(2) The services of the plan are not reasonably accessible to subscribers and enrollees.

(3) The plan, or a person employed by the plan, has failed to comply with licensing or certification requirements imposed by law.

(4) The plan is operating in a manner which is unfair, unreasonable or discriminatory as to its subscribers and enrollees or as to its enrollment practices.

(5) The financial condition of the plan is such that its continued operation will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has engaged in conduct proscribed by Subparagraphs (6), (7), (8), (9), (10) or (11) of Section 1386(b) of the Act.

(7) The plan has violated any condition of this exemption; provided that nothing contained herein shall be construed to permit reliance upon this exemption notwithstanding noncompliance with all its provisions.

(c) For the purposes of this section, "rural service area" means a geographic area which is predominantly rural and which contains no part of any city or town (as "city" and "town" are defined by Sections 20 and 21 of the Government Code) the population of which is 25,000 or more.

(d) For the purposes of this section, "ambulance services" means the emergency and nonemergency transportation by a person licensed pursuant to Articles 1 and 2 of Chapter 2.5 of Division 2 of the Vehicle Code of persons who are ill, injured, or wounded, and such health care services as are provided for the duration of such transportation.

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 9-30-76 as an emergency; effective upon filing (Register 76, No. 40).

2. Certificate of Compliance filed 1-27-77 (Register 77, No. 5).

3. Amendment filed 4-2-79; effective thirtieth day thereafter (Register 79, No. 14).

4. Editorial correction of subsections (a)7.f. and (b)(6) (Register 80, No. 4).

5. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).

6. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

7. Change without regulatory effect updating title references in Notice filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).

28 CCR 1300.43.6 (2002)

§ 1300.43.6. Moribund Plans

A health care service plan which is a general acute care hospital whose business as a plan is limited to providing, administering, or otherwise arranging for the provision of health care services to members of one moribund group of not more than 250 members is exempted from the provisions of the Knox-Keene Health Care Service Plan Act of 1975, subject to each of the following conditions:

(a) That such plan is licensed as a health facility pursuant to Chapter 2 (commencing with Section 1250) of the Health and Safety Code, and is not insolvent.

(b) That such plan has not accepted any new members for the last twenty years and does not accept any new members for the duration of this exemption.

(c) That such plan receives prepaid or periodic charges, if any, from members of such group in an amount not exceeding $ 5 per member per month and has received no substantial payment or transfer of property from or on behalf of such contracting group during the last twenty years.

(d) That such plan derives not more than one-half of one percent of its annual income from prepaid or periodic charges paid by or on behalf of members of such group, and has a minimum net worth of $ 15,000,000 based upon its most recent certified financial statements (prepared as of a date within the preceding 15 months).

(e) That such plan establish and maintain a grievance procedure substantially complying with Section 1300.68.

(f) That such plan deliver to each subscriber and enrollee within 60 days of the adoption of this section, and thereafter to any subscriber or enrollee upon request, the following written notice:

"(Name of plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975 PROVIDED BY RULE OF THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA."

AUTHORITY:

Note: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 6-13-78 as an emergency; effective upon filing (Register 78, No. 24).

2. Certificate of Compliance filed 8-18-78 (Register 78, No. 33).

3. Editorial correction of subsection (f) (Register 95, No. 12).

4. Change without regulatory effect amending subsection (f) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

28 CCR 1300.43.10 (2002)

§ 1300.43.10. Nonprofit Retirees' Plan

A health care service plan which was registered under the Knox-Mills Health Plan Act as in effect on June 30, 1976, whose activity as a plan is limited to reimbursing part or all of the cost of health care services as a supplement to Medicare (Parts A and B) to persons who were retired from professions associated with higher learning after having been employed therein for not less than 10 cumulative years and such persons' spouses, providing all such persons are enrolled in Medicare, is exempted from the provisions of Section 1349 of the Knox-Keene Health Care Service Plan Act of 1975, subject to each of the following conditions:

(a) That such plan is a nonprofit corporation which does not engage, directly or indirectly, in any for profit business, which is not affiliated with (Rule 1300.45(c)) a corporation or other entity which engages, directly or indirectly, in any for profit business, and which does not contract or otherwise arrange for the performance by persons other than its directors, officers or employees of any portion of its administrative or other functions.

(b) That such plan is exempted from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code and from state income tax on similar grounds.

(c) That such plan is a charitable corporation subject to, and in compliance with, the Uniform Supervision of Trustees for Charitable Purposes Act.

(d) That such plan does not directly provide any health care services through entity-owned or contracting health facilities or providers.

(e) That such plan has a tangible net equity within the meaning of Section 1300.76(b) of not less than $ 300,000, including liquid tangible assets in an amount not less than $ 300,000, based upon its most recent certified financial statement (prepared as of a date within the preceding 15 months and such other date as may be requested by the Director pursuant to Section 1384 of the Act) and its most recent quarterly and monthly uncertified statements prepared on a basis consistent with the annual certified statement, with additional liquid tangible assets in an amount not less than $ 1,000 for each person enrolled in excess of 400; provided that the maximum number of enrollees shall not exceed 500.

(f) That not more than 15% of the total charges paid by or on behalf of subscribers or enrollees for enrollment in, or for health care benefits from, such plan is expended for administrative costs, including all costs of solicitation and enrollment; except that such plan may expend additional sums of money for administrative costs excluding costs of solicitation and enrollment provided that such money is not derived from revenue obtained from subscribers or enrollees.

(g) That such plan issues a uniform health care service plan contract to all subscribers

(1) which provides, except for a permissible calendar year deductible not to exceed $ 100 per enrollee, full coverage for all copayments and deductibles relating to allowable charges under Medicare (Parts A and B) for all health care services covered by Medicare (Parts A and B) pursuant to Title XVIII of the Social Security Act as amended, and not less than 50% of the reasonable charges for each health care service which is not covered by Medicare but is covered by such plan; provided, however, that such coverage may be subject to a lifetime limitation allowing not less than $ 300,000 of benefits per lifetime and

(2) which provides that an enrollment or subscription may not be cancelled except upon grounds complying with Section 1365 of the Act.

(h) That such plan provides to each subscriber a disclosure statement covering the provisions of its health care service plan contract which complies substantially with the provisions of Section 1363 of the Act and which also states, if such is the case, that such contract does not cover, and that subscribers and enrollees will be solely liable for,

(1) any charges in excess of allowable charges under Medicare with respect to health care services covered by Medicare,

(2) any charges in excess of reasonable charges for any health care services covered by such plan but not covered by Medicare and any copayments related to such health care services, and

(3) any permissible plan deductible.

(i) That no less than 75% of the officers and of the directors of such corporation are persons who are retired from the professions associated with higher learning after having been employed therein not less than 10 cumulative years, are enrolled in Medicare, and are enrolled in such plan subject to terms and conditions no more favorable than any other enrollee, and that no officer or director receives any compensation from such corporation.

(j) That such plan solicits enrollments or subscriptions in this state only through persons who are officers or employees of such plan.

(k) That such plan establishes and maintains a grievance procedure substantially complying with Section 1300.68 of these rules.

(l) That such plan not represent any contract of such plan as a Medicare supplement contract and discloses to each prospective subscriber and enrollee when presenting any information regarding the plan, and again at the time of application, the following written notice:

"THE HEALTH PLAN CONTRACT OFFERED BY (Name of plan) DOES NOT MEET THE REQUIREMENTS FOR CERTIFICATION AS A MEDICARE SUPPLEMENT CONTRACT PURSUANT TO APPLICABLE STATE OR FEDERAL LAW, AND HAS NOT BEEN CERTIFIED. PERSONS DESIRING INFORMATION REGARDING CERTIFIED MEDICARE SUPPLEMENT COVERAGE SHOULD CONTACT THEIR LOCAL MEDICARE OFFICE."

(m) That such plan delivers to each subscriber and enrollee within 60 days of the adoption of this section, and annually thereafter, the following written notice:

"(Name of plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. COMPLAINTS REGARDING THIS PLAN, THE ADMINISTRATION THEREOF, AND THE SERVICES PROVIDED THEREBY MAY BE DIRECTED TO THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA."

(n) That such plan provides written notice to the Director of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of such plan, together with a signed opinion of legal counsel to the effect that such plan complies with subsections (a), (b), (c), (d) and (g) of this section.

AUTHORITY:

Note: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 11-21-79; effective thirtieth day thereafter (Register 79, No. 47).

2. Amendment filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

3. Change without regulatory effect amending subsections (e), (m) and (n) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

28 CCR 1300.43.13 (2002)

§ 1300.43.13. Mutual Benefit Plans

A health care service plan which is a bona fide mutual benefit society within the meaning of this section and which was registered under the Knox-Mills Health Plan Act as in effect on June 30, 1976 is exempted from the provisions of the Knox-Keene Health Care Service Plan Act, except as otherwise indicated below, subject to each of the following conditions:

(a) That such a plan is a corporation organized and operating as a California nonprofit corporation; does not engage, directly or indirectly, in any for-profit business; is not affiliated (Rule 1300.45(c)) with any other plan or with any corporation or other entity which engages, directly or indirectly, in any for-profit business; and does not contract or otherwise arrange for the performance

of any portion of its administrative functions by persons other than its officers, directors, or employees.

(b) That such plan consists of a mother lodge and not more than one subordinate lodge; provided, however, that such mother lodge and any such subordinate lodge are located in a county whose population exceeds 1,500,000 persons.

(c) That the assets and funds available for the payment of health care services are held in trust by and under the sole control of the mother lodge exclusively for the benefit of the beneficiary members of the mother lodge and any subordinate lodge.

(d) That such plan is exempted from federal income tax as an organization described in Section 501(c)(8) of the Internal Revenue Code and from state income tax on similar grounds.

(e) That such plan is in compliance with the Uniform Supervision of Trustees for Charitable Purposes Act (Article 7 (commencing with Section 12580) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code.)

(f) That such plan not practice any discrimination in violation of state or federal law or constitutional provision.

(g) That the beneficial membership in such plan is limited to beneficial members of the mutual benefit society (including only the mother lodge and any subordinate lodge) and consists of a total of not more than 800 persons.

(h) That such plan not receive any prepaid or periodic charges, except that admission fees of not more than $ 500 per each beneficial or social member may be received and dues of not more than $ 100 per each beneficial or social member per year may be received, provided, however, that no part of any admission fees or membership dues may be deposited in the health care trust or used to pay for or reimburse any part of the cost of health care services.

(i) That such plan, at all times while it relies upon this exemption, has a tangible net equity within the meaning of Section 1300.76(b) of not less than $ 500,000, including liquid tangible assets in an amount not less than $ 500,000, based upon its most recent annual certified financial statement and its most recent quarterly and monthly statements prepared on a basis consistent with the annual certified statement, with additional liquid tangible assets in an amount not less than $ 1,000 for each beneficial member in excess of 700; provided that the maximum number of beneficial members shall not exceed 800.

(j) That such plan, upon request of the Director, pursuant to Section 1384(a) of the Act, submits to the Director a copy of its most recent annual certified financial statement, and, upon request of the Director pursuant to Section 1384(f) of the Act, submits to the Director its most recent quarterly and monthly statements prepared on a basis consistent with the annual certified statement.

(k) That such plan issues to all beneficial members health care service plan contracts which provide at least all of the benefits indicated below, except that such contracts may diminish or qualify any of the benefits indicated below through the use of such copayments, limitations, and other terms as may be determined from time to time by vote of the plan's beneficial members:

(1) Physician services (including consultation and referral) through contracting physicians;

(2) Hospital inpatient services through at least one contracting nonprofit, nongovernmental hospital;

(3) Hospital outpatient services through at least one contracting nonprofit, nongovernmental hospital when prescribed by the treating, contracting physician.

(l) That all of the plan's contracts with providers comply with, and recite that the contracting providers are bound by, the provisions of Section 1379 of the Act.

(m) That such plan provides to each beneficial member a disclosure statement covering the provisions of its health care service plan contract which complies substantially with the provisions of Section 1363 of the Act.

(n) That the officers and directors of such corporation are enrolled in such plan subject to terms and conditions no more favorable than any other beneficial member, and that no officer or director receives any compensation from such corporation.

(o) That such plan solicits beneficial members in this state only through persons who are officers, directors, or employees of such plan, and not by means of any unsolicited telephone call or written or printed communication or by radio, television, or similar communications media.

(p) That such plan establishes and maintains a grievance procedure substantially complying with Section 1368 of the Act.

(q) That such plan delivers to each beneficial member within 60 days of the effective date of this section, and annually thereafter, the following written notice:

"(Name of Plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. COMPLAINTS REGARDING THIS PLAN, THE ADMINISTRATION THEREOF, AND THE SERVICES PROVIDED THEREBY MAY BE DIRECTED TO THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA."

(r) That such plan provides, within 60 days of its initial reliance on this section, and within 30 days of any subsequent request of the Director therefor, written notice to the Director of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of such plan, together with a signed opinion of legal counsel to the effect that such plan complies with subsections (a), (b), (c), (d), (e), (f), (g), (h), (i), (k), (l), and (m) of this section.

AUTHORITY:

Note: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1343 and 1344, Health and Safety Code.

HISTORY:

1. New section filed 6-5-84; effective thirtieth day thereafter (Register 84, No. 23).

2. Change without regulatory effect amending subsections (j) and (q)-(r) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.43.14. Employee Assistance Programs

(a) A health care service plan which, pursuant to a contract with an employer, labor union or licensing board within the Department of Consumer Affairs, consults with employees, members of their families or licensees of such board to identify their health, mental health, alcohol and substance abuse problems and refer them to health care providers and other community resources for counseling, therapy or treatment, is exempt from the provisions of the Act (other than Sections 1360, 1360.1, 1368 and 1381, relating to advertising, client grievance procedures and the inspection of records by the Director) if the plan complies with each of the following provisions, and the contracts of a licensed health care service plan are exempt from the provisions of the Act if they comply with each of the following provisions:

(1) The plan has filed a notice with the Director as provided in subsection (c) within the preceding 24 months.

(2) The purpose of the contract, insofar as it relates to the provision of services to clients is either

(A) to maintain or improve employee efficiency through identification and referrals for counseling, treatment or therapy, in connection with personal problems affecting employee performance and the contract does not provide for counseling, treatment or therapy with respect to health, mental health, alcohol or substance abuse problems or

(B) to identify alcohol and substance abuse problems or mental health or health problems of DCA licensees and refer them to appropriate health care providers or organizations for treatment, and the plan does not provide for counseling, treatment or therapy with respect to health, mental health, alcohol or substance abuse problems.

(3) No client or member of his or her family, directly or indirectly shall pay any prepaid or periodic charge under the contract or pay any copayment, fee or other charge for any service rendered under the contract in connection with a health, mental health, alcohol or substance abuse problem. The payment of regular union dues by an employee, a license fee by a DCA licensee, or of a benefit payment by an employer on behalf of an employee and members of the employee's family which does not affect the employee's compensation or other benefits is not a "prepaid or periodic charge" for the purpose of this subsection.

(4) If such plan, its employees or contracting consultants, or an affiliate of any of the foregoing, has a financial interest in referrals made under the contract in connection with a health, mental health, alcohol or substance abuse problem, such person prior to making any such referral shall disclose to the contracting employer, union or state licensing agency and to the person who is referred, the existence of such financial interest; provided that neither the plan nor its employees shall receive any payment, fee or commission directly or indirectly from any person to whom an employee, licensee or family member is referred for counseling, treatment or therapy. The disclosure requirement to the employer may be a single blanket disclosure provided it identifies the providers to which referrals will be made and identifies the financial interest involved.

(5) The number of sessions with any client under the contract shall not exceed 3 within any six month period.

(6) Except as otherwise provided in Division 2 (commencing with Section 500) of the Business and Professions Code, the plan shall maintain a record for a period of not less than two years of each session with a client concerning a health, mental health, alcohol or substance abuse problem, and each consultation excluded from the definition of "session." The record shall include the name of or identifier for the client, the date and purpose of the session and the outcome if any, including the name of the provider to which the client was referred. The employee assistance program contracts and the records specified pursuant to subparagraph (6) shall be available for inspection by the Director as provided in Section 1381 of the Act.

(7) The plan and the personnel, facilities and equipment of the plan, including that employed under contract, shall be licensed or certified when required by applicable law and persons engaged in identification and referral who are not licensed under Division 2 of the Business and Professions Code shall be certified by any of the following organizations:

(A) Any organization accredited by the National Commission for Accreditation of Alcohol/Drug Abuse Counselors' Credentialing Bodies, Inc.

(B) Alcoholism Council of California.

(C) California Association of Alcoholism and Drug Abuse Counselors.

(D) Association of Labor-Management Administrators and Consultants on Alcoholism.

(8) Unless the plan is licensed under the Act, no prepaid fees shall be collected more than 45 days in advance.

(b) For the purposes of this section the following definitions apply:

(1) "Client" means the employee, the employee's family member, the DCA licensee or other person eligible for the services provided under the plan contract.

(2) "DCA licensee" means a licensee of the Department of Consumer Affairs.

(3) "Session" means any in-person or telephone consultation with the client in connection with the client's health, mental health, alcohol or substance abuse problems, excluding a consultation that occurs in an acute emergency situation, a consultation after referral for motivation or re-referral or a consultation due to a management, state licensing agency or union request for information or assessment regarding work performance issues.

(c) The notice specified in subsection (a)(1) shall be in the following form and contain the information specified below:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

NOTICE OF EMPLOYEE ASSISTANCE PROGRAM
EXEMPTION RULE 1300.43.14,
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT

( ) Original Notice ( ) Amendment to Notice Dated---

The person/entity named in Item 1 below files this notice/amended notice claiming the exemption pursuant to Rule 1300.43.14 under the Knox-Keene Health Care Service Plan Act:

1. Legal name of person or entity filing this notice:

...

2. Address of principal office, and if different, mailing address:

...

...

3. Fictitious names used in connection with the operation of employee assistance programs (if none, so specify):

...

4. Identify each location at which the plan maintains records subject to inspection by the Director under Rule 1300.43.14(a)(6) (if space is insufficient, continue on separate sheet):

...

...

...

5. Name, title, address and telephone number of representative who may be contacted concerning this notice:

6. The person/entity filing this notice declares hereby that it is in compliance with the provisions of Rule 1300.43.14, and undertakes to amend this notice within 30 calendar days of any material change in the information specified in its current notice as filed with the Director of the Department of Managed Health Care.

Date of Notice ---

(Name of Person/Entity Filing Notice)

--- ---

(Signature of Authorized Officer)

(Printed Name and Title of Signatory)

Verification:

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this Notice and its attachments thereto and know the contents thereof and that the statements therein are true and correct.

Executed at ..... on .....

(City and State) (Date)

(Signature)

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 6-12-87; operative 6-12-87 (Register 87, No. 28).

2. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).

3. Change without regulatory effect amending subsections (a)-(a)(1), (a)(6) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

28 CCR 1300.43.15 (2002)

§ 1300.43.15. Foreign Plans

(a) There is exempted from the provisions of the Act (other than Sections 1360, 1360.1, 1381 and 1395) any plan whose activity in this state is limited to the offer and sale of plan contracts for enrollees who are residents of or domiciled in a foreign country, provided:

(1) the provision of health care services by the plan, and the receipt of consideration from persons located in this State, does not violate any law of the foreign country in which the enrollee resides or any law of the United States,

(2) the annual premium per enrollee does not exceed $ 200 (US),

(3) the solicitors or solicitor firms authorized to solicit on behalf of the plan are physically present in this state, and

(4) the plan has filed a notice with the Director as provided in subsection (b) within the preceding 24 months.

(b) The notice specified in subsection (a) shall be in the following form and contain the information specified below:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

NOTICE OF FOREIGN PLAN EXEMPTION
RULE 1300.43.15, KNOX-KEENE HEALTH CARE
SERVICE PLAN ACT

( ) Original Notice ( ) Amendment to Notice Dated ...

The person/entity named in Item 1 below files this notice/amended notice claiming the exemption pursuant to Rule 1300.43.15 under the Knox-Keene Health Care Service Plan Act:

1. Legal name of person or entity filing this notice:

2. Address of principal office, and if different, mailing address:

3. List name, address and telephone number of authorized solicitors or solicitor firms who will be soliciting on behalf of the plan in this state. (Continue on separate sheet if space is insufficient.)

4. Name, title, address and telephone number of representative who may be contacted concerning this notice:

5. The person/entity filing this notice declares hereby that it is in compliance with the provisions of Rule 1300.43.15, and undertakes to amend this notice within 30 calendar days of any material change in the information specified in it current notice as filed with the Director of the Department of Managed Health Care.

Date of Notice ---
(Name of Person/Entity Filing Notice)

--- ---
(Signature of Authorized Officer)

(Printed Name and Title of Signatory)

Verification:

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this Notice and its attachments thereto and know the contents thereof and that the statements therein are true and correct.
Executed At ..... on ..... 19.....

(Signature)

AUTHORITY:

Note: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 9-8-88; operative 10-8-88 (Register 88, No. 38).

2. Change without regulatory effect amending subsections (a)(4) and (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.45. Definitions

In addition to the definitions contained in Section 1345 of the Act, the following definitions apply to the interpretation of these rules and the Act:

(a) "Act" means the Knox-Keene Health Care Service Plan Act of 1975.

(b) "Advertisement" includes the disclosure form required pursuant to Section 1363 of the Act.

(c) (1) An "affiliate" of a person is a person controlled by, under common control with, or controlling such person.

(2) A person's relationship with another person is that of an "affiliated person" if such person is, as to such other person, a director, trustee or a member of its executive committee or other governing board or committee, or that of an officer or general partner, or holds any other position involving responsibility and authority similar to that of a principal officer or general partner; or who is the holder of 5% or more of its outstanding equity securities; or who has any such relationship with an affiliate of such person. An affiliate is also an affiliated person.

(d) The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting shares, debt, by contract, or otherwise.

(e) The term "certified" or "audited," when used in regard to financial statements, means examined and reported upon with an opinion expressed by an independent public or certified public accountant.

(f) "Code" means the California Health and Safety Code.

(g) "Copayment" means an additional fee charged to a subscriber or enrollee which is approved by the Director, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

(h) "Department" means the California Department of Managed Health Care.

(i) "Facility" means

(1) any premises owned, leased, used or operated directly or indirectly by or for the benefit of a plan or any affiliate thereof, and

(2) any premises maintained by a provider to provide services on behalf of a plan.

(j) "Family unit" means a unit composed of a subscriber and each person whose eligibility for benefits is based upon such person's relationship with, or dependency upon, such subscriber.

(k) "Hospital based plan" means a health care service plan which owns, operates or is affiliated with a hospital as an integral part of delivering health care services.

(l) "Material": A factor is "material" with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

(m) "Primary care physician" means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice

of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

(n) "Principal creditor" means

(1) a person who has loaned funds to another for the operation of such other person's business, and

(2) a person who has, directly or indirectly, 20 percent or more of the outstanding debts of a person.

(o) "Principal officer" means a president, vice-president, secretary, treasurer or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

(p) "Surcharge" means an additional fee which is charged to a subscriber or enrollee for a covered service but which is not approved by the Director, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

(q) The term "generally accepted accounting principles," when used in regard to financial statements, assets, liabilities and other accounting items, means generally accepted accounting principles as used by business enterprises organized for profit. Accordingly, Financial Accounting Standards Board statements, Accounting Principles Board opinions, accounting research bulletins and other authoritative pronouncements of the accounting profession should be applied in determining generally accepted accounting principles unless such statements, opinions, bulletins and pronouncements are inapplicable. Section 510.05 of the AICPA Professional Standards, in and of itself, shall not be sufficient reason for determining inapplicability of statements, opinions, bulletins and pronouncements.

AUTHORITY:

Note: Authority cited: Sections 1344 and 1352, Health and Safety Code. Reference: Sections 1351, 1351.1 and 1352, Health and Safety Code.

HISTORY:

1. Amendment of subsection (c) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).

2. New subsection (q) filed 4-27-79; effective thirtieth day thereafter (Register 79, No. 17).

3. Amendment of subsection (e) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

4. Amendment of subsection (c) filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).

5. Change without regulatory effect amending subsections (g)-(h) and (p) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.47. Advisory Committee on Managed Health Care

Each member of the Advisory Committee on Managed Health Care shall file with the Director a statement setting forth the following:

(a) The firm with which such member is employed or affiliated and the capacity in which employed or affiliated.

(b) Whether such firm is a health care service plan or solicitor firm under the Act or is a provider, or a fiscal intermediary for a plan, or furnishing services, goods or facilities to any plan, solicitor firm or provider.

(c) Whether such member has any financial interest in any firm specified in (b) or receives compensation from such firm.

(d) The name of each plan in which the member is enrolled, or has been enrolled during the preceding 10 years.

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1347, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

2. Change without regulatory effect amending section heading and first paragraph filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.51. Application for License as a Health Care Service Plan or Specialized Health Care Service Plan

(a) An application for license as a health care service plan or specialized health care service plan shall be filed in the form specified in subsection (c) and contain the information specified in this section and prepared as required by Rule 1300.51.3.

(b) Applications filed prior to the effective date of subsection (c) (revised plan application form) and which remain pending on that date will be processed; however, amendments to such applications filed prior to licensure shall be filed upon the form specified in subsection (c) in accordance with the instructions specified in Rule 1300.51.3, and in accordance with the correlation

table for the old and new applications provided in Form HP 1300.51-COR. Such amendments will be required only to update the information contained in the application and to remedy deficiencies in the information provided therein.

(c) Revised Health Care Service Plan Application Form.

[See Table In Original]

1. Name of Applicant.
a. Legal name:---
b. Please list all fictitious names you intend to use
---

2. Applicant's Principal Executive Office.
a. Street Address:---
b. Mailing Address:---
c. Telephone Number: ( )---

3. Person who is to receive communications regarding this filing.
(Note: Prior to licensure, the Department will correspond only with this person.)
a. Name:...
b. Title:...
c. Address:...
d. Telephone Number: ( )...

4. EXECUTION: The applicant has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.

By:...
Signature of individual
signing on behalf of Applicant

... Name:...
(Applicant) (Typed or printed)

Title:...

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this application and the exhibits and attachments thereto and know the contents thereof, and that the statements therein are true and correct.

Executed at ..... on ..... .
(City and State) (Date)

(Signature)

A. Type of Filing: Indicate the type of filing by checking and completing the appropriate items:

1. ( ) Original application for a plan license.

2. ( ) Amendment #.... to a pending application dated ..... for plan license. (Complete Item A-5 below.)

3. ( ) Notice of a proposed material modification in the form required by Rule 1300.52.1. (Complete Item A-5 below.)

4. ( ) Amendment filed by a licensee pursuant to Section 1352(a) because of a change in the information contained in the original application. (See Rule 1300.52 and complete Item A-5 below.)

5. Item numbers being amended...
Exhibit numbers being amended ...

B. Type of Plan Contract(s): Indicate the type of a plan contract(s) by checking and completing the statements which most nearly describe the plan:

1. ( ) Full Service Health Plan Contracts which provide as benefits at least the six basic health care services listed in Section 1345(b) of the Act. (Check types below as appropriate.)
( ) Commercial
( ) Waxman-Duffy prepaid health plan contract
( ) Other Medi-Cal (Explain)...
( ) MediCare Supplement
( ) Other (Explain)...

2. Specialized Health Plan Contract(s)
( ) Dental ( ) Vision ( ) Mental Health
( ) Other...

3. ( ) Contracts with subscribers and enrollees which are not limited to a single specialized area of health care but do not provide as benefits at least the six basic health care services listed in Section 1345(b) of the Act.

C. Name and address or officer or partner of applicant who is to receive compliance and informational communications from the Department and is responsible for disseminating the same within applicant's organization. (Note: After licensure, and except with respect to amendments and material modifications, the Department will correspond only with this person, unless the Department and applicant agree to other arrangements.)

a. Name:...
b. Title:...
c. Address:...
d. Telephone Number: ( )...

D. Other Agencies.

1. If applicant is seeking or intends to seek federal qualification under the Federal Health Maintenance Organization Act of 1973, check here .....

2. If applicant has made or intends to make any filing relating to its plan to any other state or federal agency, check here ....., and attach Exhibit D-2 identifying each such agency, and the nature, purpose and (projected) date of each such filing.

Additional Exhibits: An original application for health care service plan license must include the completed form specified in this subsection and the exhibits required by Subsection (d).

(d) Exhibits to Plan Application.

E. Summary of Information in Application.

1. Summary Description of Plan Organization and Operation. Provide as Exhibit E-1 a summary description of the organization and operation of applicant's business as a health care service plan, covering the highlights and essential features of the information provided in response to the other portions of this application which is essential or desirable to an effective overview of the applicant health care service plan business.

2. Summary Description of Start-up. Provide as Exhibit E-2 a concise description of applicant's start-up program and its assumptions. Indicate applicant's projected date for the beginning of plan operations, and discuss the factors which require such date.

F. Organization and Affiliated Persons.

1. Type of Organization.

a. Corporation. If applicant is a corporation, and attach as Exhibits F-1-a-i, F-1-a-ii and F-1-a-iii, respectively, the Articles of Incorporation, Bylaws, and the Corporation Information Form. (Form HP 1300.51-A)

b. Partnership. If applicant is a partnership, and attach as Exhibits F-1-b-i, and F-1-b-ii, respectively, the Partnership Agreement, and the Partnership Information Form. (Form HP 1300.51-B)

c. Sole Proprietor. If applicants a sole proprietorship, and attach as Exhibit F-1-c the Sole Proprietorship Information Form. (Form HP 1300.51-C)

d. Other Organization. If applicant is any other type of organization, and attach as Exhibit F-1-d, Articles of Association, trust agreement, or any other applicable documents, and any other organizational documents relating to the conduct of the internal affairs of the applicant, and attach as Exhibit F-1-d-ii the Information Form for other than Corporations, Partnerships, and Sole Proprietorships. (Form HP 1300.51-D)

e. Public Agency. If applicant is a public agency, and attach as Exhibit F-1-e-i a description of the public agency, its legal authority, organization, decision making body. Also attach as Exhibit F-1-e-ii a description of the division or unit of the public agency which is to be responsible for operating the plan, its legal authority, organization, and decision making role. Also attach as Exhibit F-1-e-iii the name and address of the local public agency which is the plan.

f. Individual Information Sheet. Attach as Exhibit F-1-f, an Individual Information Sheet (Form HP 1300.51.1) for each natural person named in any exhibit in Item F-1.

2. Contracts with Affiliated Persons, Principal Creditors and Providers of Administrative Services.

a. Persons to Be Identified. Attach as Exhibit F-2-a list identifying each individual or entity who is a party to a contract with applicant, if such contract is one for the provision of administrative services to the applicant or any such party is an Affiliated Person or Principal Creditor (Rule

1300.45(c) and (n)) or of the applicant. As to each such person, show the following information in columnar form:

(i) The names in alphabetical order.

(ii) The exhibit and page number of the contract (including loans and other obligations).

(iii) The type of contract of loan.

(iv) Each relationship which such individual or entity bears to the applicant (officer, director, partner, trustee, member, Principal Creditor, employee, administrative services provider, health care services provider, or shareholder).

(v) Whether (yes or no) such individual or entity is intended to become a Principal Creditor (Rule 1300.45(n)) of applicant.

(vi) Whether (yes or no) such individual or entity is intended to become an "Affiliated Person" of applicant, or to become an Affiliated Person in any capacity other than that disclosed in item F-2-a-iv.

b. Copies of Contracts. Attach as Exhibit F-2-b a copy of each contract (other than a contract for the provision of administrative services or health care services furnished pursuant to Items K or N below) identified in Item F-2-a. Preceding the first page of each such contract, attach a summary sheet which

(1) identifies the contract,

(2) specifies its terms, including its expiration date, and

(3) if a loan or obligation, specifies the unpaid balance of principal and interest and states whether applicant is in default upon the loan or obligation.

3. Other Controlling Persons. Does any individual or entity not named as a contracting party in Item F-2 or any exhibit thereto have any power, directly or indirectly, to manage, influence, or administer the operation, or to control the operations or decisions, of applicant?

If the appropriate response to this item is "yes," attach as Exhibit F-3 a statement identifying each such person or entity and explaining fully, and summarizing every contract or other arrangement or understanding (if any) with each such person. (Each such contract should be submitted pursuant to Subsection F-2 or Subsection G-2, as appropriate.)

4. Criminal, Civil and Administrative Proceedings. Within the preceding 10 years, has the applicant, its management company, or any Affiliate of the applicant (Rule 1300.45(c)), or any controlling person, officer, director or other person occupying a principal management or supervisory position in such plan, management company or Affiliate, or any person intended to hold such a relationship or position, been convicted of or pleaded nolo contendere to a crime, or been held to have committed any act involving dishonesty, fraud or deceit in a judicial or administrative proceeding to which such person was a party?

If "yes," attach a separate exhibit as to each such person designated Exhibit F-4, identifying such person and fully explaining the crime or act committed. Also, attach a copy of the exhibit for an individual to any Individual Information Sheet required by Item F-1-f for such individual.

5. Employment of Barred Persons. Has the plan engaged or does the plan intend to engage, as an officer, director, employee, associate, or provider, any person named in any order of the Director pursuant to Section 1386(c) or Section 1388(d) of the Act? If the appropriate response to this item is "yes," attach as Exhibit F-5 a statement identifying each such person and explaining fully.

G. Miscellaneous.

1. Consent to Service of Process. If applicant is not a California corporation, attach as Exhibit G-1 a Consent to Service of Process, in the form required by Rule 1300.51.2.

2. Disclosure of Financial Information. Attach as Exhibit G-2, authorizations for the disclosure of financial records of the applicant, and of any association, partnership or corporation controlling, controlled by or otherwise affiliated with the applicant pursuant to Section 1351.1 of the Act. (See Items F-3 and F-5.)

HEALTH CARE DELIVERY SYSTEM

H. Geographical Area Served.

Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.

For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.

An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any inference that a plan which does not meet these guidelines does not meet the requirement of reasonable accessibility.

(i) Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.

(ii) Hospitals. In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.

(iii) Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting

staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.

(iv) Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

1. Description of Service Area. As Exhibit H-1, attach a narrative description of the applicant's service area and the geographic area in which its enrollees (actual and/or projected) live and work and list all U.S. Postal ZIP Code numbers included in the service areas. If the applicant has more than one service area, each service area should be separately described. To the extent possible, service areas should be delineated by political or natural boundaries. (If applicant uses sub-service areas or regions within its service areas for the purpose of allocating the provision of health care services by providers to enrollees, include that information in the description of the considerations which underlie the geographic distribution of the applicant's contracting and plan-operated providers.)

2. Map of Service Area. As Exhibit H-2, attach a map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) employed should be of convenient size and of the largest scale sufficient to include the applicant's entire service area and the surrounding area in which the actual or projected enrollees live or work. The use of good-quality city street maps or the street and highway maps available for various metropolitan areas, and regions of the state, such as are commonly available from automobile associations or retail service stations is preferred. The map or maps should show the following information:

a. Such geographic detail, including highways and major streets, as is generally portrayed on the kinds of maps referred to above.

b. The boundaries of applicant's service area.

c. The location of any contracting or plan-operated hospital and, if separate, each contracting or plan operated emergency health care facility. Hospitals are to be designated by an "H" and emergency care facilities by an "E."

d. The location of primary care providers, designated by a "P." For convenience, the primary care providers within any mile-square area may be considered as being at one location within that area.

e. The location of all other contracting or plan-operated health care providers including the following: Dental, designated by a "D." Pharmacy, designated by an "Rx." Laboratory, designated by an "L." Eye Care, designated by an "O." Specialists and ancillary health care providers, designated by an "S."

f. The location of all subscriber groups which have submitted letters of intent or interest to join the applicant's plan designated by a "G." (See Item CC-3.)

3. Index to Map. As Exhibit H-3, attach an index to the map or maps furnished as Exhibit H-2 which shows, for each symbol placed on the map for a hospital, emergency care facility, primary care provider or ancillary provider, the following information:

a. For each hospital, its total beds and the number of beds available to enrollees of the plan.

b. For each symbol for primary care providers, the number of full-time equivalent primary care providers represented by that symbol.

c. For each interested subscriber group, the name of the group and the projected number of enrollees from that group.

I. Description of Health Care Arrangements.

Note: Providers of Health Care Services. The information in this item is for the purpose of assessing the adequacy of the applicant's health care provider arrangements.

If the service area of the plan and the distribution of its enrollees is so geographically limited that all plan health care providers are readily available and accessible to all enrollees, no geographic division of the provider information required in this part need be made.

However, if applicant's service area is divided into separate provider networks for regions within the service area, the information required in this Item-1 must be furnished separately for each such region and provider network.

1. Physicians Services.

a. Individual Physicians. As Exhibit I-1-a list all individuals who provide covered physician services as employees of the plan or, whether directly or through an association or other entity, as contracting providers: For each physician, furnish the following information.

(i) Name.

(ii) License Number.

(iii) Type of service as determined by board certification and eligibility. Primary care physicians should be designated as general practice, pediatrics, obstetrics, gynecology and internal medicine. Specialists should be designated as allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, surgeries, otolaryngology, urology, and other designated as appropriate.

(iv) The plan-owed or contracting hospitals at which the physician has admitting staff privileges.

(v) The professional address of the physician.

(vi) The physician's relationship to the plan (employed by or contracting with the plan, or contracting through an IPA or one of the parties identified in Item I-1-a.

(vii) The percentage of the physician's time allocated to enrollees of the plan.

(viii) The business hours of the physician's office (i.e., Monday through Friday 8-5, closed Wednesdays).

b. Physician Associations. For all entities other than individuals or independent practice associations who contract with applicant to provide physician services, and each plan-operated facility at which physician services are rendered by employees of the plan, as Exhibit I-1-b furnish the following information for each such contractor or facility:

(i) The name of the contractor or facility.

(ii) The street address of the contractor or facility at which the physician services are rendered for the particular region or provider network.

(iii) The type of entity (professional corporation, sole proprietor, partnership, etc.).

(iv) The number of physicians rendering services for the plan by reason of such contract or by employment at such facility, and the number of "full-time equivalent" physicians being provided to enrollees of the plan.

2. Hospitals. Attach as Exhibit I-2 a list of all hospitals which are operated by or contract with the plan. Provide the following information for each hospital:

a. Its legal name and any "dba" (fictitious name under which it does business).

b. Its address.

c. Its license number.

d. Whether it is a member of the American Hospital Association, whether it is currently accredited by the Joint Commission on the Accreditation of Hospitals, (JCAH) and the expiration date of its current accreditation.

e. Its bed capacity and rate of occupancy.

f. Its emergency room capabilities.

g. A list and full description of all services available to enrollees. Applicant may use a JCAH form or the equivalent.

h. Its relationship with applicant (owned by, contracting provider, joint venture with applicant, etc.).

3. All Other Providers of Health Care Services. Attach as Exhibit I-3 a list of all providers of health care service contracting with or owned by the applicant which are not included in the physician and hospital listings. For each such provider, furnish the following information:

a. The legal name of the provider and any "dba."

b. Its address.

c. Its license number.

d. The health care services it provides to enrollees of the plan (e.g., home health agencies, ambulance company, laboratory, pharmacy, skilled nursing facility, surgi-center, mental health, family planning, etc.).

e. Its hours of operation and the provision made for after-hours service.

f. An appropriate measure of the provider's capacity to provide health care service, the existing utilization of such services by other than enrollees of the plan and the projected use of the services by enrollees.

g. The provider's relationship to the plan (owned by, contracting with, etc.).

4. Calculation of Provider-Enrollee Ratios. As Exhibit I-4, furnish a calculation of the adequacy of the applicant's provider arrangements for each region or provider network within applicant's service area. This should be based on the full range of the health care services covered by the

applicant's full-service or specialized plan contracts, the extent to which contracting and planned-owned or employed providers are available to provide such services, the enrollee population served by such providers and the adequacy of the provider system in each category based on standard utilization data. Assumptions employed in such calculations should be stated, including the extent to which paraprofessionals and allied health personnel will be used by applicant or providers and the protocols and method of supervision of such personnel.

5. Applicant's Standards of Accessibility. Attach as Exhibit I-5 a detailed description of the applicant's standards with respect to the accessibility and its procedures for monitoring the accessibility of services. Standards should be expressed in terms of the level of accessibility which the applicant has as its objective and the minimum level of accessibility below which corrective action will be taken. Cover each of the following:

a. the availability of appointments for primary care and specialty services,

b. the availability of after hours and emergency services,

c. an assessment of probable patient waiting times for scheduled appointments,

d. the proximity of specialists, hospitals, etc. to sources of primary care, and

e. a description of applicant's system for monitoring and evaluating accessibility. (Discuss applicant's system for monitoring problems that develop, including telephone inaccessibility, delayed appointment dates, waiting time for appointments, other barriers to accessibility, and any problems or dissatisfaction identified through complaints from contracting providers or grievances from subscribers or enrollees.)

f. the contractual arrangements utilized by the applicant to assure the monitoring of accessibility and conformance to standards of accessibility by contracting providers.

6. Referrals. Attach as Exhibit I-6 a detailed description of applicant's system of documentation of referrals to physicians or other health professionals. Include:

a. the provisions made for written documentation of the referral policies and procedures,

b. the procedures for following up on contracting and noncontracting referrals, including turnaround times, and

c. applicant's arrangements for paying for services delivered by noncontracting providers.

J. Internal Quality of Care Review System.

Applicant is required to demonstrate that it has a system for the review of the quality of health care to identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization and the cost of services. The following exhibits require a description and explanation of the system, including narrative, organization and process charts and review criteria. See Rule 1300.70.

1. Organization and Operation. As Exhibit J-1, furnish a description of the basic structure, organization and authority of the applicant's quality of care review system, including:

a. An organization chart showing the key persons, the committees and bodies responsible for the conduct of the review system, the provisions for support staff and the relationship of such persons, committees and bodies to the general organization of the plan. See Item J-4 below.

b. A narrative explanation of the review system covering the matters depicted in the organization chart and the following: the key persons involved, their titles and their qualification; the extent and type of support staff; the areas of authority and responsibility of the key persons and the committees, if divided among persons and committees; the frequency of meetings of the committees and the portion of their time devoted to the review system by key persons. See Item J-4 below.

2. Standards and Norms. Attach as Exhibit J-2 a description of the standards and norms of the system (including any measurement of deviation in their application), and indicate how these standards and norms will be communicated to providers.

3. Operation of System. Attach as Exhibit J-3 a description of the operation of the review system, including the frequency and scope of audits, the utilization of the audit results and the procedures and methods for the enforcement of the standard and norms of the system.

4. Administration of System by Providers. If portions of the review system are administered by contracting providers, by affiliates of the applicant or by other persons who are not officers or employees of the applicant, attach Exhibit J-4 identifying those portions of the system together with the providers, affiliates or persons administering them on behalf of the applicant, and describe and furnish copies of the contractual provisions which assure the maintenance of the system to the standards of the applicant and those of the Act and the rules thereunder.

5. Monitoring of Provider Administration. Attach as Exhibit J-5, a description of the contractual arrangements which will be employed to enable the plan to monitor, and require, compliance with the quality of care review system, to the extend such system is administered by such contracting providers.

K. Contracts with Providers.

1. Copies of Contracts. Attach as Exhibit K-1 a copy of each contract made, or to be made, between applicant and each provider of health care services. If a contract shows the payment to be rendered a provider, delete such minimum portion of the contract as is necessary to prevent disclosure of such information, by blanking out or other suitable means.

a. If standard form contracts are used, only a specimen of each type of form contract need be filed together with any variations to be used in the terms and provisions of such standard forms, other than in the amount of payments to providers.

b. The contracts and other information submitted in this exhibit will be available for public inspection (see Section 1351(d)).

2. Compliance with Requirements. Attach as Exhibit K-2 a statement in tabular form for each provider contract, and for each standard form contract and its variations, if any, specifying the provisions of such contract which comply with the following provisions of the act and rules:

Section 1379
Rule 1300.67.1(a) and (c)
Rule 1300.67.2(b), (c) and (f)
Rule 1300.67.4(a)(9) and (10)
Rule 1300.67.8(a), (b), (c) and (d)
Rule 1300.68
Rule 1300.70

Rule 1300.51, Item J-5

3. Compensation of Health Care Providers. Attach as Exhibit K-3 one copy of the following provisions from each provider contract, or proposed provider contract, from which payment information was deleted in Exhibit K-1 and clearly mark the extracts from each contract "confidential":

a. The title page of the contract or other information sufficient to identify the contract submitted as Exhibit K-1 to which the extract relates and the providers who are parties.

b. The effective date of the contract and its expiration date.

c. The provisions describing the mechanism by which payments are to be rendered to the provider, including any risk sharing arrangement, clearly identified by the name of the provider.

d. The provider's signature on the execution page of the contract, with the name of the provider typed beneath the signature.

ADMINISTRATION OF THE PLAN

L. Organization Chart.

Attach as Exhibit L an organization chart which shows the lines of responsibility and authority in the administration of the applicant's business as a health care service plan. One chart should be limited to the applicant itself, showing its management and operational structure, including the names and titles of key positions and its board. If necessary, a second chart should show the total management structure of the business in all areas, and including the key positions and departments of the applicant and those in any affiliate and/or contracting provider of health care and/or administrative services, including but not limited to the particular management functions required in the administration of a health care delivery system. The charts are to show the names of the corporations, partnerships and other entities involved in such administration, their boards, committees, and key management positions involved, giving the names of the boards, committees and positions and the persons serving therein.

M. Narrative Information.

1. Attach as Exhibit M-1 a narrative explanation of the organization chart, including the responsibility and authority of each entity, board, committee and position and identifying the persons who serve on such boards and committees and in such positions.

2. Attach as Exhibit M-2, a statement as to each individual who is a member of a board or committee or who occupies a position specified in Exhibit L and Exhibit M-1, covering the following:

a. Name.

b. Each position (e.g., director, officer, committee member, key management personnel and the managers of key departments) such person holds which is indicated in Exhibits L and M-1, whether with applicant, an affiliate or a contracting provider of health, administrative or other services. Also state the person's principal responsibilities and authority in each position, and the portion of the individual's time devoted to each principal function.

c. A resume or similar description of such person's training and experience during the preceding five years (or longer, if desired) which are relevant to the duties and responsibility in applicant's business as a health care service plan.

N. Contracts for Administrative Services.

1. As Exhibit N-1, attach a copy of each contract which applicant has for administrative or management services, or consulting contracts, or which applicant intends to have for the Health Plan.

2. As Exhibit N-2, describe applicant's administrative arrangements to monitor the proper performance of such contracts and the provisions which are included in them to protect applicant, its plan business and its enrollees and providers in the event there is a failure of performance or the contract is terminated.

O. Attach as Exhibit O a statement describing how the Health Plan organization will provide for separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced by fiscal and administrative management. Describe what controls will be put into place to assure compliance with this requirement. Refer to appropriate items in Exhibit "J," Internal Quality of Care Review System.

SUBSCRIBER CONTRACTS, DISCLOSURES, AND RELATIONS

Note: In Items P and Q, the applicant is required to include as exhibits copies of the health care service contracts it will issue, including standard form contracts and any variations in the provisions of those forms. In addition, the applicant is required to identify the particular provisions of these contracts which comply with the provisions of the Act and rules listed at the end of this note, or which vary from those provisions. The applicant is also required to explain its proposed variations (if any) from the Act or rules, giving the reasons and justifications for such variances.

The provisions of the Act and rules required to be covered in the information furnished pursuant to Items P and Q are the following:

All Plan Contracts

Section		Rule	
	1345 (definitions)		1300.45 (definitions)
	1362 (definitions)		1300.63(a) (only if used
	1363 (only if used for		as evidence of coverage)
	evidence of coverage)		1300.63.1 (only if used
	1365		as evidence of coverage)
	1367.6		1300.63.2 (only if used as
	1367.8		evidence of coverage)
	1373		1300.67.4
	1373.4		1300.68(b)

Group Contracts Only

Section
1367.2
1367.3
1367.5
1367.7

1373.1
1373.2
1373.5
1373.6
1374
1374.10

P. Group Health Care Service Plan Contracts.

1. Copies of Contracts. Attach as Exhibit P-1 a copy of each group contract which is to be issued by applicant. With respect to contracts based on a standard form, only a specimen of each standard form need be submitted, accompanied by Exhibit P-2.

2. Variations in Standard Form. Attach as Exhibit P-2, if applicant uses standard form group contracts, a schedule or explanation of the variations which will be made in the terms and provisions of such contracts when issued. If no variations will be made, so state.

3. Compliance with Requirements. Attach as Exhibit P-3 a schedule in tabular form for each group contract and each standard form group contract, identifying the particular provision of such contract which complies with each relevant provision of the Act and the rules listed in the preface note to this part, covering also any variations made in standard form contracts. As to any provision which varies from the applicable provision of the Act or rules, identify such provision in Exhibit P-3 and furnish Exhibit P-4.

4. Variance with Requirements. As Exhibit P-4, attach a statement with respect to each variance which the applicant proposes to make from the Act or rules in its group contracts, indicating the reasons for the variance and, if applicable, the circumstances under which the variance from the Act or rules is proposed to be used.

Q. Individual Health Care Service Plan Contracts.

1. Copies of Contracts. Attach as Exhibit Q-1 a copy of each individual contract which is to be issued by applicant. With respect to contracts based on a standard form, only a specimen of each standard form need be submitted, accompanied by Exhibit Q-2.

2. Variations in Standard Form. Attach as Exhibit Q-2, if applicant uses standard from individual contracts, a schedule or explanation of the variations which will be made in the terms and provisions of such contracts when issued. If no variations will be made from the standard form, so state.

3. Compliance with Requirements. Attach as Exhibit Q-3 a schedule in tabular form for such individual contract and each standard form individual contract, identifying the particular provision of such contract which complies with each relevant provision of the Act and rules listed in the preface note to this part, covering also any variations to be made in standard form contracts. As to any provision which varies from the applicable provision of the Act or rules, identify such provision in Exhibit Q-3 and furnish Exhibit Q-4.

4. Variance from Requirements. As Exhibit Q-4, attach a statement with respect to each variance which the applicant proposes to make from the Act or rules in its individual plan contracts, indicating the reasons for the variance and, if applicable, the circumstances under which the variance from the Act or rules is proposed to be used.

R. (Reserved for future use.)

S. Disclosure Forms.

1. Attach as Exhibit S-1 a copy of each disclosure form which applicant proposes to use, and identify by name and by exhibit number the contract or contracts in Exhibit P-1 or Q-1 with which the disclosure form will be used. If the disclosure forms vary in text, format and arrangement in a manner which may make it difficult to identify and compare alternatives and their effect upon the contract, include an explanation which indicates how such difficulties will be avoided.

2. Attach as Exhibit S-2 a statement in tabular form for each disclosure form submitted as Exhibit S-1 above, identifying the section, paragraph, or page number of the disclosure form which shows compliance with each of the following sections of the Act or rules (following the parenthetical instructions set forth in the note immediately preceding Item P above, if there are multiple disclosure forms):

Section 1345 (definitions)	Rule 1300.67(a)(1)
1362 (definitions)	1300.63(b)(1) through (14)
1363(a)(1) through (8)	
1363(a)(10)	
1378(g) (if disclosing group contract)	

T. Evidence of Coverage.

1. Attach as Exhibit T-1 a copy of each evidence of coverage which applicant proposes to use. Each evidence of coverage should relate to one form of plan contract which must be identified by name and by exhibit number; however, an evidence of coverage for alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract and if the alternative contracts are clearly identified by name or exhibit number.

2. Attach as Exhibit T-2 a statement in tabular form for each evidence of coverage submitted as Exhibit T-1 above, the section, paragraph, or page number of the evidence of coverage which shows compliance with each of the following sections of the Act or rules (following the parenthetical instructions set forth in the note immediately preceding Item P above, if there are multiple evidences of coverage):

Section 1345 (definitions)	Rule 1300.63(a)(1)
1362 (definitions)	1300.63.1(b)(1) and (2)
	1300.62.2(b)(1) and (2)
	1300.63.2(c)(1) through (16)
	1300.69(i)

U. Combined Evidence of Coverage and Disclosure Forms.

Applicant may combine the evidence of coverage and disclosure form into one document if it complies with each of the requirements set forth in Rule 1300.63.2.

1. Attach as Exhibit U-1 a copy of each combined evidence of coverage and disclosure form. Each combined evidence of coverage and disclosure form should relate to one form of plan contract; however, a combined evidence of coverage and disclosure form offering alternative plans

or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

2. Attach as Exhibit U-2 a statement in tabular form for each combined evidence of coverage and disclosure form submitted as Exhibit U-1 above, the section, paragraph or page number which shows compliance with each of the following sections of the Act or Rules (following the parenthetical instructions set forth in the note immediately preceding Item P above, if there are multiple combined evidences of coverage and disclosure forms):

Section 1345 (definitions)	Rule 1300.63.2(b)(1) and (2)
1362 (definitions)	1300.63.2(c)(1) through (27)
1300.69(i)	

V. Advertising.

Attach as Exhibit V a copy of any advertising which is subject to Section 1361 of the Act and which applicant proposes to use. With respect to each proposed advertisement indicate the contract(s) by name and by exhibit number(s) to which said advertisement relates and identify the segment of the public to which the advertisement is directed.

W. Enrollee/Subscriber Grievance Procedures.

1. Attach as Exhibit W-1 a copy of its written grievance procedure adopted or to be adopted by applicant to comply with all of the provisions of Section 1368 of the Act and Rules 1300.68, 1300.85 and 1300.85.1.

2. Attach as Exhibit W-2, copies of the compliant forms and the written explanation of its grievance procedure which the plan will make available to enrollees and subscribers.

3. If the written procedure furnished as Exhibit W-1 does not identify the key personnel of applicant and provider organizations that will be responsible for carrying out its grievance procedures and the review of its results, attach Exhibit W-3 giving the name and title of each such person and identifying their responsibility for carrying out the procedure.

X. Public Policy Participation.

1. If applicant is in compliance with the requirements of the Federal Health Maintenance Organization Act of 1973 and intends to rely on such compliance to satisfy the provisions of Section 1369 of the Act, attach as Exhibit X-1 documentation necessary to validate compliance with the Health Maintenance Organization Act.

2. Unless applicant has satisfied the provisions of Section 1369 of the Act in the manner indicated in Subsection X-1, above, attach as Exhibit X-2 a description of applicant's procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan, including at least the following:

a. the composition of applicant's governing board,

b. the composition of the standing committee established which shall participate in establishing the public policy of the plan as defined in Section 1369 of the Act, the frequency of said committee's meetings, the frequency of receipt by applicant's governing body of said committee's reports and recommendations, and the procedures established by the governing body for dealing with such reports and recommendations;

c. the means by which subscribers and enrollees participating in established public policy will be given access to information and information regarding the specific nature and volume of complaints received by applicant and their disposition;

d. specific identification by name and section or paragraph number of pertinent provisions of applicant's bylaws and/or other governing documents (as submitted in response to Item F) which set forth the procedures for public policy participation for subscribers and enrollees; and

e. the manner and frequency with which applicant will furnish to its subscribers and enrollees a description of its system for their participation in establishing public policy and communicate material changes affecting public policy to subscribers and enrollees.

MARKETING OF PLAN CONTRACTS

Y. Marketing of Group Contracts.

Attach as Exhibit Y a statement describing the methods by which applicant proposes to market group contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation and the methods by which applicant will obtain compliance with Rules 1300.59, 1300.61, 1300.76.2, and 1300.85.1.

Z. Marketing of Individual Contracts.

Attach as Exhibit Z a statement describing the methods by which applicant proposes to market individual plan contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation and the methods by which applicant will obtain compliance with Rules 1300.59, 1300.61, 1300.76.2, and 1300.85.1.

AA. Supervision of Marketing.

Attach as Exhibit AA a statement setting forth applicant's internal arrangements to supervise the marketing of its plan contracts, including the name and title of each person who has primary management responsibility for the employment and qualification of solicitors, advertising, contracts with solicitors and solicitor firms and for monitoring and supervising compliance with contractual and regulatory provisions.

BB. Solicitation Contracts.

1. Attach as Exhibit BB-1 a list of all persons (other than any employee of the plan whose only compensation is by salary) soliciting or agreeing to solicit the sale of plan contracts on behalf of the applicant. For each such person, identify by exhibit number that person's contract furnished pursuant to Item BB-2 and, if such contract does not show the rate of compensation to be paid, specify the person's rate of compensation.

2. Attach as Exhibit BB-2, a copy of each contract or proposed contract between applicant and the persons named in Exhibit BB-1 for soliciting the sale of or selling plan contracts on behalf of applicant. If a standard form contract is used, furnish a specimen of the form, identify the provision and terms of the form which may be varied and include a copy of each variation.

3. If the rate of compensation for any solicitor or for any plan contract exceeds 5 percent of the prepaid or periodic charge for the contract(s) on an annual basis, attach as Exhibit BB-3 a statement explaining and justifying the rate of compensation in each such case.

CC. Group Contract Enrollment Projections.

Note: All projections required by Items CC, DD, EE and HH are to cover the period commencing from its commencement of operations as a licensed health care service plan until the applicant's financial statement projections under Item HH demonstrate that it has reached the break-even point (or for one year, whichever is longer) and for an additional period of one year thereafter. For the initial period, all projections are to be on a monthly basis. For the additional year, all projections are to be on a quarterly basis.

1. Projections. Attach as Exhibit CC-1 projections of applicant's enrollments under group contracts for the periods specified in the above note. (Medi-Cal, Medicare, and Medicare supplemental programs are to be treated as individual contracts under Item DD below.) Exhibit CC-1 is to contain the following information with respect to each anticipated group contract:

a. The name of the group.

b. The number of potential subscribers in the group.

c. The locations within and around applicant's service area in which the potential subscribers and enrollees live and work.

d. The estimated date (or period after licensing) for entry into the group contract.

e. Identification of the plan contract anticipated with the group, by reference to Exhibit P-1. If more than one type of group contract is expected with a group, each contract must be covered separately.

f. The projected number of (1) subscribers and (2) enrollees (including subscribers), on a monthly basis for the initial period specified in the above note and quarterly for the following year.

g. State whether the contract will be "community rated" or "experience rated."

h. Evaluation of the competition for each group.

2. Substantiation of Projections. Attach as Exhibit CC-2 for each group contract specified in Exhibit CC-1 a description of the facts and assumptions used in connection with the information specified in that exhibit and include documentation of the source and validity of such facts and assumptions.

3. Letters of Interest. Attach as Exhibit CC-3 letters of interest or intent from each group listed in Exhibit CC-1, on the letterhead of the group and signed by its representative.

DD. Individual Contract Enrollment Projections.

1. Projections. Attach as Exhibit DD-1 a projection of applicant's sales of individual contracts for the periods specified in the note in Item CC above. Programs involving Medi-Cal, Medicare and Medicare supplemental coverages are to be treated as individual contracts. The exhibit is to contain the following information as to each type of individual contract:

a. A description (e.g., ethnic, demographic, economic, etc.) of each target population.

b. The estimated number of persons in each target population.

c. The distribution of the target population within and around applicant's service area.

d. The projected number of (1) subscribers and (2) enrollees (including subscribers) expected to be obtained from each target population, on a monthly basis for the initial period and quarterly for the following year.

e. State whether the contract will be "community rated" or "experience rated."

f. Evaluation of the competition within the target area.

2. Substantiation of Projections. Attach as Exhibit DD-2 a statement of the facts and assumptions employed with respect to the information furnished for each contract and target population listed in Exhibit DD-1 and furnish documentation, including reliable market surveys, validating the facts and assumptions.

EE. Summary Enrollment Projections.

Attach as Exhibit EE summary enrollment projections on a monthly basis for the initial period specified in the note to Item CC and on a quarterly basis for the following year. Such enrollment projections should reflect the breakdown of enrollment by groups, individuals, Medi-Cal, Medicare, and others.

FF. Prepaid and Periodic Charges.

1. Determination of Prepaid Charges. Attach as Exhibit FF-1, a description of the method used by applicant to determine the prepaid or periodic charges fixed for individual and group contracts, including the method by which administrative and other indirect costs are allocated. Describe the facts and assumptions upon which such charges are based (e.g., contract mix, family size) and furnish supporting documentation to substantiate the validity of the facts and assumptions used.

2. Schedule of Prepaid Charges. Attach as Exhibit FF-2-a complete schedule of the prepaid or periodic charges assessed subscribers under each group contract identified in response to Item P and attach as Exhibit FF-2-b a schedule of the prepaid or periodic charges assessed subscribers under each individual contract identified in response to Item Q.

3. Collection of Prepaid Charges. Attach as Exhibit FF-3 a description of the manner in which applicant will collect prepaid and periodic charges and copayments from subscribers and enrollees under its group and individual contracts. If prepaid or periodic charges will be paid by subscribers to an entity other than the plan, identify the entity and specify the measures used by the plan to safeguard and account for such funds (see Rules 1300.76.2, 1300.85 and 1300.85.1).

FINANCIAL VIABILITY

GG. Current Financial Viability, Including Tangible Net Equity.

1. Financial Statements.

a. Attach as Exhibit GG-1-a the most recent audited financial statements of applicant, accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant, together with all footnotes to said financial statements.

b. If the financial statements attached as Exhibit GG-1-a are for a period ended more than 60 days before the date of filing of this application, also attach as Exhibit GG-1-b financial statements prepared as of date no later than 60 days prior to the filing of this application consisting of at least a balance sheet, a statement of income and expenses, and any accompanying footnotes; these more

recent financial statements need not be audited, so long as they are prepared in accordance with generally accepted accounting principles.

2. Tangible Net Equity. Attach as Exhibit GG-2 a calculation of applicant's tangible net equity in accordance with Rule 1300.76, based on the most recent balance sheet submitted as Exhibit GG-1-a or b above.

HH. Projected Financial Viability

1. Attach as Exhibit HH-1, the following projected financial statements of the applicant reflecting actual and projected changes which have, or which are expected to occur between the date of its most recent financial statements furnished pursuant to Item GG and the date specified for the commencement of its operations as a plan in Item E above. The projected financial statements must be prepared in accordance with generally accepted accounting principles and on a basis consistent with the financial statements supplied in Item GG.

a. Applicant's projected balance sheet as of the start up date of the plan. (See Item E)

b. Applicant's projected statement of income and expenses covering the period between the date of the most recent financial statements furnished in Item GG and the date specified in Item E.

c. A calculation of applicant's projected tangible net equity in accordance with Rule 1300.76 as of the date specified in Item E and in accordance with its projected balance sheet.

2. Attach as Exhibit HH-2, projected financial statements as of the close of each month during applicant's initial period of operations, as defined in the note to Item CC, and as of the close of each quarter for the following year, prepared on a consistent basis with the financial statements furnished for Item HH-1, including the following:

a. Applicant's projected balance sheet as of the close of such month or quarter.

b. Applicant's projected statement of income and expense for such month or quarter.

c. Applicant's projected cash-flow statement for such month or quarter.

d. A calculation of applicant's tangible net equity pursuant to Rule 1300.76 as of such month or quarter.

e. A calculation of applicant's administrative costs pursuant to Rule 1300.78 for such month or quarter.

3. Furnish the following information to substantiate the assumptions and conclusions upon which the projections required by Items HH-1 and HH-2 are based:

a. Attach as Exhibit HH-3-a the complete results of feasibility studies obtained by applicant as normally required by conventional lending institutions, including at least the following: legal, marketing/enrollment, providers and financial.

b. Attach as Exhibit HH-3-b an actuarial report which includes at least the following information for all enrollees reflected in Exhibit EE as covered by contracts which are community rated:

(i) Utilization rates for each medical expense item reflected in applicant's income statements furnished pursuant to Item HH-2, expressed in terms of utilization units per member per month, including the methodology and source of data used to determine such rates.

(ii) The cost per utilization unit for each medical expense item reflected in the income statement, including the methodology and source of data used to determine such costs.

(iii) The per member per month cost for each medical expense item.

(iv) The methodology and source of data used to estimate copayments, coordination of benefits, and reinsurance recoveries, including the expression of such items on a per member per month basis.

(v) Inflation estimates used in the projections and the source utilized to determine such estimates.

c. For each contract which is designated as experience rated (as summarized in Exhibit EE) attach as Exhibit HH-3-c an actuarial report for the contract which conforms to the requirements stated in Item HH-3-b.

d. Attach as Exhibit HH-3-d a summary schedule which reflects the breakdown of the total revenue and expense included in the projected income statements in Exhibit HH-2-b by community rated contacts and experience rated contracts.

e. As Exhibit HH-3-e the assumptions made by the applicant to determine the time lag between the delivery by covered health care services and applicant's payment for those services. Also indicate all other assumptions made in preparing the projected cash flow statements in Item HH-2-c.

f. Attach as Exhibit HH-3-f-i a detailed description of any measures taken or proposed to be taken by applicant to maintain compliance with the tangible net equity requirement under Rule 1300.76 and the financial viability requirement under Rule 1300.76.1 in view of losses and expenditures prior to reaching a break-even point in its operations. This information should include a schedule setting forth the amounts of any additional needed funding and the dates when such amounts will be infused into applicant. If such arrangements involve arrangements for additional capital, to subordinate or postpone the payment of accounts, notes or other obligations of the plan or other agreements, cite the exhibit numbers of such agreements and identify their applicable provisions, if supplied elsewhere in the application, or if not otherwise furnished, attach copies of such agreements or proposed agreements, identifying the parties thereto and their relationship to the plan and its affiliates.

If any funding is to be obtained from an entity other than a national bank or a bank incorporated under the laws of this state, attach as Exhibit HH-3-f-ii a copy of such entity's most recent annual audited and quarterly unaudited financial statements.

4. Reimbursements. Attach as Exhibit HH-4 the following information regarding applicant's projected reimbursements:

a. Monthly and quarterly projections as specified in the note to Item CC for each of the following (see instruction in Item 4-b):

(i) Payments to reimburse noncontracting providers for covered health care services furnished to enrollees (see Section 1377(a)).

(ii) Payments to reimburse enrollees for covered health care services furnished by noncontracting providers (see Section 1377(a)).

(iii) Total reimbursements for services by noncontracting providers (1) plus (2) (see Section 1377(a)).

(iv) Fee-for-service payments to reimburse contracting providers for covered health care services.

(v) Total reimbursements (3) plus (4).

(vi) Total expenditures by applicant for covered health care services.

(vii) The ratio of total reimbursements to total health care expenditures (5) divided by (6).

(viii) The ratio of reimbursements for services by noncontracting providers to total expenditures (3) divided by (6).

b. Describe and substantiate the facts and assumptions upon which the projections are based, including those for fee-for-service payments to contracting providers and document the source and validity of such assumptions. (Actuarial studies or comparable information should be furnished in response to these items.)

c. If the ratio of total reimbursements to total expenditures in Item 4-a (viii) exceeds 10%, specify the measures by which applicant will comply with Section 1377(a) of the Act and Rules 1300.77 and 1300.77.3. If applicant will maintain reserves as specified in Section 1377(a)(1) of the Act, specify the size of the reserve and the fiscal impact upon applicant arising from its maintenance.

d. If the ratio of total reimbursements to total expenditures in Item 4-a(vii) exceeds 10%, specify the measures by which applicant will comply with Section 1377(b) of the Act and Rules 1300.77.1, 1300.77.2 and 1300.77.3.

5. Administrative Costs. If applicant's administrative costs (as defined in Rule 1300.78) as projected for its initial period of operation (as specified in the Note to Item CC and calculated pursuant to Item HH-2-e) exceed 25% of the prepaid or periodic charges paid by or on behalf of subscribers, and if such administrative costs exceed 20% of such charges for the following year, attach as Exhibit HH-5 a calculation of the percentage of administrative costs to such charges for both such periods and furnish information which explains the necessity for the level of administrative costs projected and the manner in which applicant will reduce such costs to not more than 15% of such charges within five years after licensure.

6. Provision for Extraordinary Losses. The following requirements require an initial applicant to submit legible copies of the actual policies of insurance (including any riders or endorsements) or specimen copies of the policies of insurance which show all of the terms and conditions of coverage, or with respect to those items expressly allowing for self-insurance, allow applicant to provide evidence of self-insurance at least as adequate as insurance coverage.

a. Attach as Exhibit HH-6-a evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of furnishing health care services (malpractice insurance).

b. Attach as Exhibit HH-6-b evidence of adequate insurance coverage or self-insurance to respond to claims for tort claims, other than with respect to claims for damages arising out of furnishing health care services.

c. Attach as Exhibit HH-6-c evidence of adequate insurance coverage or self-insurance to protect applicant against losses of facilities upon which it has the risk of loss due to fire or other causes. Identify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate.

d. Attach as Exhibit HH-6-d, evidence of fidelity bond coverage for at least the amounts specified in Rule 1300.76.3, in the form of a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner, providing 30 days' notice to the Director of the Department of Managed Health Care prior to cancellation, and covering each officer, director, trustee, partner and employee of the plan, whether or not compensated.

e. Attach as Exhibit HH-6-e evidence of adequate workmen's compensation insurance coverage against claims which may arise against applicant.

II. Fiscal Arrangements.

1. Maintenance of Financial Viability. Attach as Exhibit II-1 a statement describing applicant's arrangements to comply with Section 1375.1(b) of the Act and Rule 1300.75.1(a)(2). If applicant will maintain insurance under these provisions, furnish a specimen of the policy, the name of the insurer and the premium cost to the policy.

2. Capitation Payments to Providers. If applicant intends to pay some or all providers on a capitation basis, attach as Exhibit II-2 a statement indicating the percentage of contracting providers who will be compensated on that basis, a description of the method used to determine and adjust the capitation rates, and substantiate by means of calculations or other information that such capitation rates are adequate to reasonably assure the continuance of the applicant/provider relationship.

3. Risk of Insolvency. Attach as Exhibit II-3 a description of the manner in which applicant will provide for each of the following in the event of applicant's insolvency:

a. The continuance of benefits to enrollees for the duration of the contract period for which payment has been made.

b. The continuance of benefits to enrollees until their discharge, for those enrollees confined in an in-patient health care facility on the date of insolvency.

c. Payments to noncontracting providers for services rendered.

4. Provider Claims. Attach as Exhibit II-4 a statement describing applicant's system for processing claims from contracting providers and noncontracting providers for payment, and from subscribers and enrollees for reimbursement, including, the rules defining applicant's obligation to reimburse, the standards and procedures for applicant's claims processing system (including receipt, identification, handling, screening, and payment of claims), the timetable for processing claims, procedures for monitoring the claims processing system, and procedures for reviewing the claims processing system in view of complaint from contracting or noncontracting providers or grievances from subscribers or enrollees. The records maintained regarding fee-for-service reimbursements must be in accordance with the provisions of Rule 1300.77.4.

5. Other Business. If the applicant is or will engage in any business other than as a health care service plan, attach as Exhibit II-5 a statement describing such other business, its relationship to applicant's business as a plan, and the anticipated financial risks and liabilities of such other

business. If the financial statements and projections in Exhibits GG-1-a, GG-1-bb, HH-1 and HH-2 do not include such other business, explain.

(e) Information Forms Required by Item F-1 of Subsection (d):

(1) Corporation Information Form.

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

EXHIBIT F-1-a-iii CORPORATION INFORMATION FORM

To be used in response to Item F-1-a of Form HP 1300.51.

---

1. Name of Applicant (as in Item 1-a)---

---

2. State of Incorporation. 3. Date of Incorporation.

---

4. Is applicant a nonprofit corporation? ( ) Yes ( ) No

---

5. Is applicant exempted from taxation as a nonprofit corporation?
( ) Yes ( ) No

---

6. Names of principal officers, directors and shareholders: List (a) each person who is a director or principal officer or who performs similar functions or duties and (b) each person who holds of record or beneficially over 5% of the voting securities of applicant or over 5% of applicant's equity securities. If this is an amended exhibit, place an asterisk (*) before the names for whom a change in title, status or stock ownership is being reported and a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

[See Table In Original]

---

7. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(2) Partnership Information Form.

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

EXHIBIT F-1-ii PARTNERSHIP INFORMATION FORM.
To be used in response to Item F-1-b of Form HP 1300.51.

---
1. Name of Applicant (as in Item 1-a).
---
2. State of organization. 3. Date of organization.
---

4. Names of Partners and Principal Management: List all general, limited and special partners and all persons who perform principal management functions. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title, status or partnership interest is being reported and place a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

[See Table In Original]

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5. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(3) Sole Proprietor Information Form.

CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

EXHIBIT F-1-c SOLE PROPRIETORSHIP INFORMATION FORM
To be used in response to Item F-1-c of Form HP 1300.51.

---
1. Name of Applicant (as in Item 1-a).
---
2. Residence Address.
---

3. Names of persons performing principal management functions: List each person who occupies a principal management position or who performs principal management functions for the applicant. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title or duties is being reported and place a double asterisk (**) before the names of persons which are being added to those furnished in the most recent previous filing of this exhibit.

[See Table In Original]

---
4. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(4) Information Form for Miscellaneous Types of Entities.

CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

EXHIBIT F-1-d INFORMATION FORM FOR MISCELLANEOUS TYPES OF ENTITIES. To be used in response to Item F-1-d of Form HP 1300.51.

---
1. Name of Applicant (as in Item 1-a)
---
2. State of Organization 3. Date of Organization
---
4. Form of Organization (describe briefly)

---
5. Names of Principal Officers and Beneficial Owners: List below the names of (a) each person who is a principal officer or trustee of the applicant or who performs principal management functions, and (b) each person who owns of record or beneficially over 5% of any class of equity security of the applicant. If this is an amended exhibit, place an asterisk (*) before the name of each person for whom a change in title, status or interest is reported, and a double asterisk (**) before the name of persons which are added to those reported in the most recent previous filing.

[See Table In Original]

---

6. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1351, 1351.1, 1352, 1359, 1363, 1367, 1367.2, 1367.3, 1367.4, 1367.5, 1367.6, 1367.7, 1367.8, 1367.9, 1367.15, 1368, 1369, 1370, 1370.1, 1373, 1373.1, 1373.2, 1373.4, 1373.5, 1373.6, 1373.7, 1373.8, 1374, 1374.7, 1374.10, 1374.11, 1374.12, 1375.1, 1376, 1378, 1386, 1399.62 and 1399.63, Health and Safety Code.

HISTORY:

1. Amendment of Item 23-C filed 12-20-77 as an emergency; effective upon filing (Register 77, No. 52).

2. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).

3. Amendment of Item 23 filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

4. Amendment of Item 22-G filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

5. Amendment filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).

6. Change without regulatory effect amending subsection (c) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).

7. Change without regulatory effect amending subsections (c), (d)F.5., (d)HH.6.d., (e)(1), (e)(2), (e)(3) and (e)(4) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

CHAPTER 2. ADMINISTRATION

ARTICLE 3. PLAN APPLICATIONS AND AMENDMENTS

28 CCR 1300.51.1 (2002)

§ 1300.51.1. Individual Information Sheet

An individual information sheet required pursuant to these rules shall be in the following form:

CONFIDENTIAL
See Note to Item 5

DEPARTMENT OF MANAGED HEALTH CARE
State of California

INDIVIDUAL INFORMATION SHEET
under the
Knox-Keene Health Care Service Plan Act of 1975

(California Health & Safety Code Sec. 1340 et. seq.)

1. Name of Applicant: File No. .....
.....

2. Exact full name of person completing this statement:

First Middle Last

3. Physical Description:
Sex.....Hair.....Eyes.....Height.....Weight.....

4. Birthdate: ..... Birthplace:.....

5. Social Security No. or
Taxpayer Ident. No: ...

NOTE: The inclusion of your social security number is not required but is voluntary. It is solicited pursuant to Sections 1344 and 1351 of the Health and Safety Code. It may be used to conduct a background investigation by the Department, the California Department of Justice Information Branch, or by other federal, state or local law enforcement agencies. This form, including the social security number, will be held confidential, but is a public record and available to the public pursuant to the Public Records Act (Gov. Code Section 6250), at the discretion of the Director.

6. Residence Telephone: 7. Business Telephone:
---

8. Current Residence Address:

Number and Street City State Zip

9. Employment for the last 5 years (list most recent first and include any employment with a plan or any person or entity which is or was affiliated with a plan (Section 1300.45(c)):

[See Table In Original]

NOTE: Attach separate schedule if space is not adequate.

10. Business contacts, dealings and affiliations (see section 1300.45(c)(2)) with health care service plans during the last 5 years (but including, for example, such roles as director, stockholder, consultant, manager, provider and supplier, and such dealings as sales, leasing, and any contractual relationships) (list most recent business contacts and dealings first):

[See Table In Original]

NOTE: Attach separate schedule if space is not adequate.

11. Have you ever had a certificate, license, permit registration or exemption issued pursuant to the Business and Professions Code or Health and Safety Code denied, revoked or suspended or been otherwise subject to disciplinary action, while you were in the employ of the applicant, or while you had a contract with the applicant as a provider or otherwise? [ ] Yes [ ] No

If "yes" state the date of the action and the administrative body taking such action.

---

12. Have you ever been convicted or pled nolo contendere to a misdemeanor involving moral turpitude or any felony, other than traffic violations?
[ ] Yes [ ] No

If the answer is "yes" give details:

---

13. Have you ever changed your name or ever been known by any name other than that herein listed? (Including a married person's prior surname, if any.)
[ ] Yes [ ] No

If so, explain. Change in name through marriage or court order should also be listed. EXACT DATE OF EACH NAME CHANGE MUST BE LISTED.

---

14. Have you ever engaged in business under a fictitious firm name either as an individual or in the partnership or corporate form? [ ] Yes [ ] No

If the answer is "yes" set forth particulars:

VERIFICATION

I, the undersigned, state that I am the person named in the foregoing Individual Information Sheet, that I have read and signed said Individual Information Sheet and know the contents thereof, including all exhibits attached thereto; and that the statements made therein, including any exhibits attached thereto, are true.

I certify/declare under penalty of perjury that the foregoing is true and correct.
Executed at---
City County State
this ..... day of ..... .

...
(Signature of Declarant)

NOTE: If this form is signed outside California complete the verification before a notary public in the space provided below.

State of...
County of...

Dated...
at...

(Signature of Affiant)

Subscribed and sworn to before me,
...

Notary Public in and for said
County and State

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1351, Health and Safety Code.

HISTORY:

1. Amendment filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

2. Amendment filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).

3. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).

4. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

28 CCR 1300.51.2 (2002)

§ 1300.51.2. Consent to Service of Process

The consent to service of process required pursuant to these rules shall be in the following form:

TO THE DIRECTOR OF THE DEPARTMENT OF
MANAGED HEALTH CARE OF
THE STATE OF CALIFORNIA

CONSENT TO SERVICE OF PROCESS

KNOW ALL MEN BY THESE PRESENTS:

That the undersigned, ...,
(a corporation organized under the laws of the State of ...)
(a partnership) (an individual) (other ...)

hereby irrevocably appoints the Director of the Department of Managed Health Care of the State of California, or his successor in office, to be his (its) attorney to receive service of any lawful process in any noncriminal suit, action or proceeding against him (it), or his (its) successor, executor, or administrator which arises under the Knox-Keene Health Care Service Plan Act of 1975 or any rule or order thereunder after this consent has been filed, with the same force and validity as if served personally on the undersigned.

For the purpose of compliance with the Corporations Code of the State of California, notice of the service and a copy of the process should be sent by registered or certified mail to the undersigned at the following address:

Name

Street Address

City State Zip Code

Dated: .....

...
By...
Title...

State of California)

County of)

On ..... before me, (here insert name and title of the officer, personally appeared ..... personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.
Signature (Seal)

Any certificate of acknowledgement taken in another state shall be sufficient in the State of California if it is taken in accordance with the laws of the place where the acknowledgement is made.

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1351, Health and Safety Code and Section 1189, Civil Code.

HISTORY:

1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).

2. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

3. Change without regulatory effect amending section and Note filed 12-7-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 49).

4. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).

5. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

28 CCR 1300.52.1 (2002)

§ 1300.52.1. Notice of Material Modification

A notice of material modification of its operations or of any plan contract pursuant to subdivision (b) of Section 1352 of the Act shall be filed as an amendment to the application as provided in Section 1300.52, and there shall be attached to such amendment, preceding the Execution Page, the following form:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

NOTICE OF MATERIAL MODIFICATION
Pursuant to
Health and Safety Code Sec. 1352(b)

1. Name of applicant:...

2. Department of Managed Health Care File Number:...

3. The fee for filing this application will be forwarded upon receipt of the billing therefore from the Director of the Department of Managed Health Care, pursuant to Health and Safety Code Section 1352(d) or pursuant to Section 1399.73 if this application involves a conversion or restructuring.

4. Pursuant to Subdivision (b) of Section 1352 of the Health and Safety Code, applicant requests approval of the material modification of its plan and/or operations, within the time specified below:

(Check appropriate box)

( ) Within the 20 business-day period provided in Section 1352(b).

( ) Applicant extends the time for action upon this notice by the Director until ....

( ) Applicant requests accelerated approval by the Director for the following reasons:

---

5. Conversion or Restructuring. If this application involves a conversion or restructuring, the applicant shall fully disclose information which describes the proposed transaction and demonstrates how the charitable trust requirements of Section 1399.72(c) of the Act will be satisfied. In addition, the applicant shall submit a copy of all of its original and amended articles of incorporation and bylaws, and a report as described in Section 1399.70(a) of the Act. If this application involves a restructuring, the applicant shall also submit a public benefit program as described in Section 1399.71(b) of the Act.

6. Exempt Restructuring Transaction. If this application involves a transaction or transactions described in Section 1399.71(e) of the Act, the applicant shall fully disclose information which describes the transaction or transactions and demonstrates how the applicable conditions of exemption of Section 1399.71(e) of the Act will be satisfied.

7. Nonprofit Mutual Benefit Health Care Service Plans.

a. Assets subject to a charitable trust obligation. If this application involves a conversion or restructuring of a nonprofit mutual benefit health care service plan with any or all of its assets subject to a charitable trust obligation, the applicant shall submit information pursuant to Item 5 or Item 6 above and, if applicant believes that partial assets are subject to a charitable trust obligation, the applicant shall fully disclose information which: (i) describes why less than all of its assets are not subject to any charitable trust obligation, (ii) explains whether any charitable trust obligation terminated for any assets previously held subject to a charitable trust obligation, and (iii) demonstrates how every noncharitable trust obligation will be satisfied.

b. Assets not subject to a charitable trust obligation. An applicant that is a nonprofit mutual benefit health care service plan must comply with Item 7. a. above unless it has established that none of its assets are subject to a charitable trust obligation. If the applicant believes that this application involves a conversion or restructuring of a nonprofit mutual benefit health care service plan with no assets subject to any charitable trust obligation, the applicant shall submit a copy of all its original and amended articles of incorporation and bylaws and fully disclose information which: (i) describes the proposed transaction, (ii) describes why all its assets are not subject to any charitable trust obligation, (iii) explains whether any charitable trust obligation terminated for any assets previously held subject to a charitable trust obligation, and (iv) demonstrates how every noncharitable trust obligation will be satisfied.

Date: ... ...
Signature of Authorized Officer

...

Title

AUTHORITY:

Note: Authority cited: Sections 1344 and 1399.74, Health and Safety Code. Reference: Sections 1352, 1399.70, 1399.71, 1399.72, 1399.73, 1399.74 and 1399.75, Health and Safety Code.

HISTORY:

1. Amendment of form paragraph 3, new form paragraphs 5 and 6 and new Note filed 6-20-96 as an emergency; operative 6-20-96 (Register 96, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-18-96 or emergency language will be repealed by operation of law on the following day.

2. Amendment of form paragraph 3, new form paragraphs 5 and 6 and new Note refiled 10-15-96 as an emergency; operative 10-18-96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2-12-97 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 10-15-96 order, including new form paragraphs 7.-7.b., transmitted to OAL 2-3-97 and filed 2-24-97 (Register 97, No. 9).

4. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

28 CCR 1300.61.3 (2002)

§ 1300.61.3. Deceptive Advertising

Without limitation upon the meaning of subdivision (a) of Section 1352.1 and subdivisions (a) and (c) of Section 1361 of the Act, an advertisement or other consumer information is untrue, misleading or deceptive if:

(a) It represents that reimbursement is provided in full for the charge for services, unless the payment by the plan fully satisfies the liability to the provider.

(b) It represents that reimbursement is provided for the customary charges for services, unless the actual experience of the plan is that there is no balance billed for covered services.

(c) It represents that the plan, solicitor firm or solicitor or any provider or other person associated therewith is licensed or regulated by the Department of Managed Health Care or other governmental agency, unless such statement is required by law or regulation or unless such

statement is accompanied by a satisfactory statement which counters any inference that such licensing or regulation is an assurance of financial soundness or the quality or extent of services. The phrase "a federally qualified health maintenance organization" and equivalent terms shall not be deemed deceptive advertising when used to refer to an organization which is so qualified under the Health Maintenance Organization Act of 1973. The display, on a plan contract which supplements Medicare with hospital or medical coverage, of the particular emblem approved by the federal Department of Health and Human Services and indicating that such contract meets the certification requirements of *42 U.S.C. 1395ss* and the regulations of the Health Care Financing Administration thereunder, or, in lieu of such emblem, of such information, if any, regarding certification as may be approved in writing as to form and content by the Director, shall not be deemed deceptive when (1) the Director has found that such contract complies with the provisions of the Act and these rules and by written notification has authorized the plan to so display such emblem or, in lieu of such emblem, such expressly approved information, if any, regarding certification and has not revoked such authorization, and (2) such contract, and any related disclosure form, evidence of coverage, printed material, and advertising, contains no untrue information regarding the emblem and does not otherwise violate this subsection.

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1352.1, 1360 and 1361, Health and Safety Code.

HISTORY:

1. New subsection (c) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).

2. Amendment filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

3. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

CHAPTER 2. ADMINISTRATION

ARTICLE 6. APPEALS ON CANCELLATION

28 CCR 1300.65.1 (2002)

§ 1300.65.1. Cancellation Complaint Form

(a) A request that the Director review cancellation of, or refusal to renew, an enrollment or subscription pursuant to subdivision (b) of Section 1365 of the Act shall be made in writing, signed by the subscriber or enrollee or the legal representative of the subscriber or enrollee and it shall be in the following form (or in letter form containing the information specified in the form below):

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

[See Table In Original]

The undersigned requests that the Director review the cancellation or refusal to renew the subscription or enrollment for health plan benefits pursuant to Section 1365 of the Knox-Keene Health Care Service Plan Act of 1975, as follows:

1. Name of person whose benefits were cancelled or not renewed: ...

2. Name of subscriber, if different than "1" above: ...

3. Name of plan: ...

4. Subscriber or Enrollee Account or Identification Number: ...

5. If applicable, the Group Identification Number: ...

6. Date notice of cancellation or refusal to renew was received: ...

7. Attach copies of:

(a) The notice of cancellation or refusal to renew received from the plan.

(b) Any correspondence with the plan regarding such cancellation or refusal to renew.

8. State why such cancellation or refusal to renew is believed to be an improper action by the plan:
...
...
...

9. Are you aware of the existence of any grounds for cancellation or refusal to renew under the terms of the agreement with the plan?
...
...
...

10. Explain why you believe that the cause or causes for cancellation enumerated in the notice of cancellation received from the Plan are inadequate or untrue. Attach copies of any documents which are relevant to your explanation.
...
...
...

11. Does such cancellation or refusal to renew prevent or interfere with providing medical care to any person currently in need of such care?

...

...

...

12. Has the person named in item 1 above whose benefits were cancelled received any medical or health care since the cancellation? If so, what services have been received and how much did they cost?

Signature of Complainant

(b) Upon receipt of a complaint pursuant to subsection (b) of Section 1365 of the Act, the Director will immediately forward a copy of such complaint to the plan, together with a request that the plan furnish the Director with

(1) a copy of the notice of cancellation or refusal to renew,

(2) a copy of any correspondence relating thereto,

(3) a statement of the reason for such cancellation or refusal to renew and

(4) a response to the complainant's allegations pursuant to Item 9 of the complaint form in subsection (a). Such information shall be returned to the Director by the plan within 10 business days following its receipt of the Director's request.

(c) Following examination of the information provided pursuant to subsection (a) and (b), the Director will notify the complainant and the plan of the determination of whether or not a proper complaint exists under the provisions of subdivision (b) of Section 1365 of the Act.

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code.

HISTORY:

1. Amendment of subsection (a) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

2. Change without regulatory effect amending form filed 5-24-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 22).

3. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

CHAPTER 2. ADMINISTRATION

ARTICLE 14. MISCELLANEOUS PROVISIONS

28 CCR 1300.89 (2002)

§ 1300.89. Petition for Restoration

(a) The fee for the filing of a petition for restoration shall be $ 100 for a solicitor, $ 250 for a solicitor firm, and $ 500 for a plan.

(b) A petition for restoration shall be made upon the following form:

[See Table In Original]

EXECUTION PAGE

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

PETITION FOR RESTORATION
UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

[See Table In Original]

1. Name of petitioner (Complete name as appearing on articles of incorporation, partnership agreement, etc.)

---

2. Address of principle office of petitioner.
(Number and Street) (City) (State) (Zip Code)

---

3. Address of principle office of petitioner in the State of California.
(Number and Street) (City) (State) (Zip Code)

---

4. Name and address of person to whom communications should be addressed concerning this petition.

---

5. The petitioner undertakes to furnish as an amendment to this petition, within 20 days of receipt of a request therefor, such additional information as the Director may require pursuant to subsection (c) of this section.

EXECUTION

The petitioner has duly caused this petition to be signed on its behalf by the undersigned, thereunto duly authorized.

[See Table In Original]

I certify under penalty of perjury that I have read this petition and the exhibits and attachments thereto and know the contents thereof, and that the statements therein are true.

[See Table In Original]

(If executed other than in a state which permits verifications under penalty of perjury, attach a verification executed and sworn to before a Notary Public.)

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6. Name and address of officer or partner of petitioner who is to receive compliance and informational communications from the Department and who is responsible for disseminating the same within the petitioner's organization.

7. Set forth the grounds upon which the license, employment, or activity was suspended, revoked, or barred.

8. Set forth the basis upon which petitioner believes that restoration is warranted.

9. Set forth the steps which petitioner has taken to prevent a recurrence of the grounds referred to in item 6, above, and any other information which petitioner believes to be relevant.

10. If the petitioner is a plan, is its application on file with the Department current without the need for any amendment?

[See Illustration In Original]

Yes

[See Illustration In Original]

No
If "no," state the day on which petitioner will comply with subsection (c) of this section.

11. If the petitioner is a plan, attach as exhibits all current reports, information, and statements which are required to be filed under the Act or rules but which have not been filed to date.

12. If the petitioner is a solicitor firm, describe the organization of petitioner, identify its principle persons, and describe the manner in which it proposes to act as a solicitor firm.

13. If the petitioner is a solicitor firm, attach financial statements as indicated.

(a) If petitioner is subject to the tangible net worth requirement of Section 1300.76.2, Title 28, Calif. Code of Regulations, attach a copy of petitioner's financial statement consisting of at least a balance sheet and statement reporting the results of operations for the petitioner, prepared as of a date within 30 days of the filing of this petition. Such financial statement need not be certified, but if not certified, also attach as an exhibit certified financial statements of the petitioner as of the close of its last fiscal year.

If petitioner is exempted from Section 1300.76.2 by subsection (b) of that section (accepting only funds in the form of checks payable to plans, subscribers or other persons contracting with plans and forwarding such checks to the payee by the close of the business day following receipt thereof), attach a statement to that effect and attach a copy of petitioner's financial statement, which need not be certified, consisting of at least a balance sheet and statement reporting the results of operations for the petitioner, prepared as of a date within 30 days of the filing of this petition.

If petitioner accepts no funds, in the form of checks or otherwise, of plans, subscribers or other persons contracting with plans (exclusive of petitioner's compensation for its solicitation activities), attach a statement to that effect, and do not include financial statements of the petitioner as an exhibit to the petition.

...

(c) If the petition provided in subsection (b) is filed by a plan, such plan shall file an amendment to its application on file with the Department which will bring that application current, or, if its application is current without the need for any amendment, it shall so allege.

(d) Depending upon the nature of the matter, the Director may require additional information and/or undertakings as a condition of granting a petition for restoration in order to determine whether such person, if restored, would engage in business in full compliance with the objectives and provisions of the Act and the rules thereunder.

AUTHORITY:

Note: Authority cited; Section 1344, Health and Safety Code. Reference: Section 1389, Health and Safety Code.

HISTORY:

1. New section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

3. Change without regulatory effect updating title reference on sample execution page filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).

CHAPTER 2. ADMINISTRATION

ARTICLE 14. MISCELLANEOUS PROVISIONS

28 CCR 1300.99 (2002)

§ 1300.99. Application to Surrender License

An application to surrender a license as a health plan shall be filed with the Director, in the following form:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

APPLICATION FOR SURRENDER OF LICENSE
PURSUANT TO
SECTION 1399, HEALTH AND SAFETY CODE

[See Table In Original]

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[See Table In Original]

AUTHORITY:

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1399, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).

3. Change without regulatory effect amending subsection (e) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).

4. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).